

# Improving Emergency Medical Services in Minnesota: A Legal Analysis of Minnesota's EMS Statutes and Regulations



**Prepared by**  
Cole Birkeland and Scott May

Students in LAW 7606: Independent Research  
Instructor: Professor Paul Vaaler  
Law School and Carlson School of Management

**Prepared in Collaboration with**  
BJ Jungmann, Legislative Chair,  
Minnesota State Fire Chiefs Association



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### **Resilient Communities Project**

University of Minnesota  
330 HHHSPA  
301 – 19th Avenue South  
Minneapolis, Minnesota 55455  
Phone: (612) 625-7501  
E-mail: [rcp@umn.edu](mailto:rcp@umn.edu)  
Web site: <http://www.rcp.umn.edu>



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Cole A. Birkeland & Scott M. May  
University of Minnesota Law School

Prepared in Collaboration with B.J. Jungmann  
Minnesota State Fire Chiefs Association

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## Introduction

This report is the product of a collaboration between the University of Minnesota Resilient Communities Project (“RCP”)<sup>1</sup> and the Minnesota State Fire Chiefs Association (“MSFCA”).<sup>2</sup> The purpose of this report is to provide a legal analysis of Minnesota’s emergency medical services statutes and regulations by comparing them to those of other states. This report will be followed by a policy analysis of Minnesota’s EMS system, which will be completed by graduate students at the Hubert H. Humphrey School of Public Affairs. Our hope is that these reports will be used to inform policy changes at the state legislature that positively impact the quality of emergency medical care Minnesotans receive throughout the North Star State.

This report contains three sections. Section I contextualizes Minnesota’s EMS statutes and regulations by providing an abridged history of EMS in general and in Minnesota, including a local news series and state supreme court case. Section II describes Minnesota’s primary service area system by explaining Minnesota’s EMS statutes and regulations and exploring their antitrust implications. Section III emphasizes the uniqueness of Minnesota’s primary service area system by summarizing key themes from the EMS statutes and regulations of all fifty states and providing a detailed survey of each state’s EMS statutes and regulations. Ultimately, this report concludes that there is substantial room for strengthening public health and safety in Minnesota by changing the state’s EMS laws.

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<sup>1</sup> See *About Us*, UNIVERSITY OF MINNESOTA, CENTER FOR URBAN AND REGIONAL AFFAIRS, RESILIENT COMMUNITIES PROJECT, <https://rcp.umn.edu/home/what-is-rcp> (last visited May 1, 2021) (“RCP strategically connects each [partner organization] with graduate and professional students and faculty at the University of Minnesota who can provide research or technical assistance to drive change . . .”).

<sup>2</sup> See MINNESOTA STATE FIRE CHIEFS ASSOCIATION, <https://www.msfc.org> (last visited May 1, 2021) (“Minnesota State Fire Chiefs Association (MSFCA) is a professional, member-driven organization, committed to representing the interests of fire departments, chiefs, command staff, officers and firefighters throughout the great State of Minnesota.”). The MSFCA also works in partnership with three other professional associations: the Minnesota Fire Department Association, the Fire Marshals Association of Minnesota, and the Minnesota Chapter of the International Arson Investigators Association.



## I. The History of EMS in Minnesota

Emergency medical services (“EMS”) is a system that provides pre-hospital emergency medical care to people who are ill or injured.<sup>3</sup> The primary means for delivering such care are ambulances, which are motor vehicles specially equipped to transport such people to a hospital.<sup>4</sup> But to understand how contemporary EMS functions as a collective system in Minnesota and elsewhere in the United States, it is helpful to possess some background knowledge of the history of EMS. The first ambulance was designed over two hundred years ago by Napoléon Bonaparte’s chief surgeon, Dominique Jean Larrey, and consisted of a horse-drawn cart used to transport wounded soldiers from battlefields to field hospitals.<sup>5</sup> Importantly, this marked the first time that patients were administered medical care *before* being transported to a hospital, as Larrey realized that providing prompt care greatly improved a patient’s chances of survival.<sup>6</sup> However, while contemporary EMS personnel can trace their lineage to Larrey’s revolutionary care to wounded soldiers on European battlefields in the early 1800s, EMS is still very much in its infancy as a profession, as modern EMS did not emerge in the United States until relatively recently, beginning in the 1960s.<sup>7</sup>

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<sup>3</sup> *What is EMS?*, NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., OFFICE OF EMS, <https://www.ems.gov/whatisems.html> (last visited Feb. 20, 2021).

<sup>4</sup> See MINN. STAT. § 144E.001(2) (2020) (defining “ambulance” as “any vehicle designed or intended for and actually used in providing [medical care] to ill or injured persons or expectant mothers.”); NAT’L ASS’N EMERGENCY MED. TECHNICIANS, *What is EMS?* (Apr. 17, 2017), <http://www.naemt.org/docs/default-source/about-ems/what-is-ems-for-web-04-17-2017.pdf> (noting that there are more than 81,000 EMS vehicles in the United States, including ambulances).

<sup>5</sup> Manish N. Shah, *The Formation of the Emergency Medical Services System*, 96 AM. J. PUB. HEALTH, no. 3, 2006, at 414; Daved van Stralen, *The Origins of EMS in Military Medicine*, J. EMERGENCY MED. SERVICES (Sept. 30, 2008), <https://www.jems.com/patient-care/origins-ems-military-medicine-2> (last visited Feb. 20, 2021).

<sup>6</sup> See Panagiotis N. Skandalakis et al., “*To Afford the Wounded Speedy Assistance*”: *Dominique Jean Larrey and Napoleon*, 30 WORLD J. SURGERY, 2006, at 1397 (“Fearful of taking patients directly to the hospital, which would delay surgery and increase the risk of hospital infection, Larrey believed that early amputation and care reduced suffering, morbidity, and mortality.”).

<sup>7</sup> Shah, *supra* note 5, at 414 (“Although modern EMS initially developed during Napoleon’s time to aid injured soldiers, few major changes occurred in EMS until the 1960s.”).

Emergency medical care remained disorganized and uneven until the 1960s and 1970s, when “a number of medical, historical, and social forces converged, leading to the development of a more structured EMS system in the United States.”<sup>8</sup> For example, in 1960, doctors combined their knowledge of mouth-to-mouth breathing and chest compressions to create the now-ubiquitous procedure of cardiopulmonary resuscitation (“CPR”).<sup>9</sup> Meanwhile, trauma was aptly recognized as a “public health crisis” when President John F. Kennedy “announced that traffic accidents . . . were a major public health problem needing attention.”<sup>10</sup> Furthermore, during the 1970s, a popular television series titled *Emergency!* portrayed the adventures of fictional Los Angeles County firefighter paramedics, which at least one author credits with “stimulat[ing] popular demand for paramedic services” and “fuel[ing] the legal changes that allowed paramedic services to develop and expand.”<sup>11</sup> In Minnesota, paramedic-staffed ambulances equipped with life-saving equipment and medications began serving the Twin Cities metropolitan area.<sup>12</sup> These ambulances belonged to various entities, including corporations<sup>13</sup>, hospitals<sup>14</sup>, and municipal fire departments<sup>15</sup>; however, a WCCO-TV investigative series in the late 1970s illustrated that there was a troubling lack of effective regulatory oversight.<sup>16</sup>

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<sup>8</sup> *Id.*

<sup>9</sup> *History of CPR*, AM. HEART ASS’N, <https://cpr.heart.org/en/resources/history-of-cpr> (last visited Feb. 20, 2021) (also noting that researchers at John’s Hopkins University unveiled the first portable external defibrillator, which weighed 200 pounds and required a wheeled cart, in 1956).

<sup>10</sup> Shah, *supra* note 5, at 415.

<sup>11</sup> Paul Bergman, *Emergency!: Send a TV Show to Rescue Paramedic Services*, 36 BALT. L. REV. 347, 356–57 (2007) (“An analysis of *Emergency!*’s influence on the rapid expansion of paramedic services must begin with the acknowledgement of the familiar bromide that ‘correlation does not equal causation.’ . . . However, ample evidence supports a conclusion that the TV show was a primary factor that fueled the legal changes that allowed paramedic services to develop and expand.”).

<sup>12</sup> See *WCCO-TV Channel 4 News*, (WCCO-TV Channel 4 television broadcasts, late 1970s) (on file with authors) (showing various ambulances that served the Twin Cities metropolitan area during the late 1970s).

<sup>13</sup> *Id.* (showing advanced and basic ambulances operated by Smith-Martin Ambulance Company).

<sup>14</sup> *Id.* (showing advanced and basic ambulances operated by Hennepin County Medical Center).

<sup>15</sup> *Id.* (showing advanced ambulances operated by the Saint Paul Fire Department and the Edina Fire Department).

<sup>16</sup> See *id.* (accusing Smith-Martin Ambulance of regularly violating ambulance regulations to maximize profit without regard for patient care, citing several disturbing examples of profit-orientated decisions that adversely affected patients). The exact dates of the WCCO-TV Channel 4 News television broadcasts are unknown; however, they must have been aired sometime between 1978 and 1980. See explanation and source cited *infra* note 27.

## A. WCCO-TV Investigative Series

In the late 1970s, WCCO-TV investigative journalist and news anchor Don Shelby exposed the conduct of a local ambulance company in a week-long investigative series on ambulance services.<sup>17</sup> Shelby accused managers of the company in question, Smith-Martin Ambulance (“Smith-Martin”), of regularly violating ambulance regulations to maximize profit without regard for patient care, citing several disturbing examples of profit-orientated decisions that adversely affected patients.<sup>18</sup> At the time, ambulances were categorized as either “advanced” or “basic.” Advanced ambulances shared the characteristics of contemporary advanced life support (“ALS”) ambulances, as they contained defibrillators, airway management equipment, and medications.<sup>19</sup> Basic ambulances shared the characteristics of contemporary basic life support (“BLS”) ambulances, as they contained simple first aid supplies, but no cardiac monitors or medications.<sup>20</sup> The personnel who staffed advanced ambulances also had greater training than those who staffed basic ambulances.<sup>21</sup>

During the week-long exposé, Shelby demonstrated how Smith-Martin routinely sent basic ambulances to calls necessitating an advanced ambulance, despite regulations that required ambulance services to notify the nearest advanced ambulance of serious medical emergencies, regardless of whether the nearest advanced ambulance belonged to the ambulance service that

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<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *WCCO-TV Channel 4 News*, *supra* note 12; see *Advanced Life Support (ALS)*, DICTIONARY.COM, <https://medical-dictionary.thefreedictionary.com/advanced+life+support> (last visited Feb. 20, 2021) (defining “advanced life support (ALS)” as “[d]efinitive emergency medical care that may include defibrillation, airway management, and use of drugs and medications”).

<sup>20</sup> *WCCO-TV Channel 4 News*, *supra* note 12; see *Basic Life Support (BLS)*, DICTIONARY.COM, <https://medical-dictionary.thefreedictionary.com/basic+life+support> (last visited Feb. 20, 2021) (defining “basic life support (BLS)” as “[e]mergency cardiopulmonary resuscitation; control of bleeding; treatment of shock, acidosis, and poisoning; stabilization of injuries and wounds; and basic first aid”).

<sup>21</sup> *WCCO-TV Channel 4 News*, *supra* note 12 (explaining the differences between advanced and basic ambulances).

received the original call or not.<sup>22</sup> In one particularly shocking example, Shelby explained how Smith-Martin dispatched a basic ambulance to a reported heart attack in the early morning hours of Christmas Eve. There were three Smith-Martin ambulances on duty that night, two of which were advanced ambulances and one of which was a basic ambulance. Both advanced ambulances were unavailable, as one was transporting a non-emergency patient to a hospital in Minneapolis and the other was assisting at the scene of a motor vehicle accident. The basic ambulance was also unavailable, as it was assisting at the scene of an unrelated motor vehicle accident.<sup>23</sup>

While all three ambulances were unavailable, a woman living at the Edina Care Center, who had a history of heart problems, began complaining of radiating shoulder and back pain.<sup>24</sup> The on-duty nurse called Smith-Martin and explained the patient's symptoms. Ambulance regulations dictated that an advanced ambulance must respond. But rather than notifying the Edina Fire Department, which had an advanced ambulance available to respond from less than three minutes away, Smith-Martin waited until one of its own ambulances was available. Approximately fifteen minutes later, the basic ambulance was dispatched to the Edina Care Center but was promptly diverted to another call. The dispatcher then requested that the advanced ambulance working at the accident scene respond to the Edina Care Center when it was done, radioing a paramedic that it "[s]ounded like it might be a coronary [heart attack]." When the advanced ambulance finally arrived—more than twenty-five minutes after the initial call—paramedics found that the patient had passed away roughly nine minutes prior to their arrival.<sup>25</sup>

Unfortunately, this was not the only instance that Shelby documented of Smith-Martin refusing to turn over an emergency call to another ambulance service with an advanced ambulance

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<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*



available to respond from closer to the scene.<sup>26</sup> Several anonymous Smith-Martin employees confirmed that management refused to turn over emergency calls to other ambulance services because they wanted the money from those calls. One employee even presented a letter of reprimand that had been given to an ambulance attendant for turning over a heart attack call to an advanced ambulance belonging to a different ambulance service. When confronted with the allegations against Smith-Martin and the question of how such deplorable practices went undetected, officials from the Minnesota Department of Health,<sup>27</sup> which was the state agency responsible for administering and enforcing ambulance regulations at the time, claimed that they lacked sufficient resources to thoroughly supervise every ambulance service.<sup>28</sup> Unsurprisingly, the public demanded changes. State lawmakers delivered, and in doing so, they essentially codified the ruling of a recent state supreme court case.<sup>29</sup>

### **B. The *Twin Ports* Case**

The Minnesota Supreme Court's ruling in *Twin Ports Convalescent, Inc. v. Minn. State Bd. of Health*, 257 N.W.2d 343 (Minn. 1977) provided a template for lawmakers who sought to change the state's EMS laws following the WCCO-TV investigative series. The *Twin Ports* case arose when two companies that provided ambulance services in Duluth ("plaintiffs") sued the Minnesota Board of Health ("board") and the recipients of a recently issued license to operate an ambulance service in the Duluth area ("defendants").<sup>30</sup> The plaintiffs sought two things:

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<sup>26</sup> *Id.*

<sup>27</sup> In 1977, the Minnesota Department of Health was established following the abolishment of the Board of Health that same year. The state agency representatives who appeared in the WCCO-TV Channel 4 News investigative series were identified as members of the Department of Health; therefore, the series must have been aired sometime between 1978 and 1980. *See* MINN. DEP'T OF HEALTH, MINNESOTA DEPARTMENT OF HEALTH OVERVIEW 2 (Jan. 14, 2019), <https://www.health.state.mn.us/about/overview.pdf>.

<sup>28</sup> *WCCO-TV Channel 4 News*, *supra* note 12.

<sup>29</sup> *See* *Twin Ports Convalescent, Inc. v. Minn. State Bd. of Health*, 257 N.W.2d 343 (Minn. 1977).

<sup>30</sup> *Id.* at 344 ("Plaintiffs, *Twin Ports Convalescent, Inc.* and *G.C.A.S., Inc.*, are Minnesota corporations which have operated ambulance services in Duluth, Minnesota, for several years. On June 16, 1975, defendant State Board of

(1) a declaratory judgment that defendants' license [was] invalid because no public hearing was held . . . to determine whether the public convenience and necessity require[d] an additional ambulance service in Duluth; and (2) a permanent injunction restraining defendants from operating an ambulance service in Duluth until they demonstrate[d] at a public hearing the requisite public convenience and necessity.<sup>31</sup>

Originally, "[t]he trial court held that defendants' license was validly issued [by the board] without a public hearing and dismissed plaintiffs' complaint."<sup>32</sup> The Minnesota Supreme Court reversed the trial court on appeal.<sup>33</sup>

The law at the center of the case was MINN. STAT. § 144.802, which was repealed and replaced as part of a comprehensive overhaul of the state's EMS statutes in 1997, but at the time provided in relevant part that:

The state board of health shall not issue licenses for the operation of newly established ambulance service in the state unless the service meets the standards required by [MINN. STAT. §§ 144.801–144.806] and the applicant has demonstrated to the satisfaction of the state board of health at a public hearing that the public convenience and necessity require the proposed ambulance service.<sup>34</sup>

Defendants attempted to persuade the Court to reject plaintiffs' claims on procedural grounds, arguing that plaintiffs lacked standing to challenge the validity of defendants' license because plaintiffs' only interest was "in keeping down the number of competitors."<sup>35</sup> The Court rejected this argument, partly because plaintiffs demonstrated "injury in fact" by alleging "that their Duluth business generated lower profits since the board issued defendants a license and defendants commenced operating an ambulance service in Duluth."<sup>36</sup>

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Health (board) issued to defendants Carl Bergl and Glen Michael (hereinafter "defendants") a license to operate an ambulance service in Duluth.").

<sup>31</sup> *Id.* at 344–45.

<sup>32</sup> *Id.* at 345.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.* (quoting MINN. STAT. § 144.802 (1977), *repealed by* 1997 Minn. Sess. Law Serv. Ch. 199, Sec. 15.

<sup>35</sup> *Id.* at 346.

<sup>36</sup> *Id.*

The Court then turned to the substantive legal issue: “what [was] a “newly established ambulance service” for which a license [could] not be issued under [MINN. STAT. § 144.802] in the absence of a public hearing and determination of public convenience and necessity.”<sup>37</sup> Defendants already possessed a valid ambulance service license issued by the Board; however, plaintiffs argued that defendants’ license “did not authorize them to operate a service in an area outside the Twin Cities.”<sup>38</sup>

Plaintiffs argue that “ambulance service” necessarily connotes a particular geographic service area and that the statute requires a public hearing whenever a service operating in one area moves to another as well as whenever a license is sought for a service new to the state.<sup>39</sup>

While plaintiffs emphasized the “particular geographic service area” in which ambulance services were granted a license to operate, defendants argued that there was no such geographic limitation on ambulance licenses, contending “that the [public] hearing requirement applie[d] only to the *initial application for service new to the state* and that once a license ha[d] been granted, the licensee [could] move freely throughout the state.”<sup>40</sup>

On one hand, the Court noted that defendants’ argument was “supported by certain statutory language as interpreted by the [Minnesota] attorney general in an opinion issued relative to [the] matter . . . and by the board’s practice of not requiring a public hearing when an ambulance service operating in one area move[d] to another.”<sup>41</sup> On the other hand, the Court noted that plaintiffs’ argument was “supported by the board’s own understanding of the purpose of the public

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<sup>37</sup> *Id.*

<sup>38</sup> *Id.* (“Plaintiffs argue on appeal that defendants’ license to operate an ambulance service in Duluth is invalid for either of two reasons: (1) Vainovskis had no “ambulance service” to transfer to defendants and thus their initial license, the basis for the second license, was improperly issued; (2) even if defendants had a valid license to operate Vainovskis’ service, that license did not authorize them to operate a service in an area outside the Twin Cities. We find plaintiffs’ latter argument persuasive and need not reach their alternative argument.”).

<sup>39</sup> *Id.* at 347.

<sup>40</sup> *Id.* (emphasis added).

<sup>41</sup> *Id.* (internal citations omitted).

hearing requirement as reflected in the procedures it ha[d] adopted to regulate those public hearings . . . and by the apparent purpose of such a requirement.”<sup>42</sup> The Court ultimately found that the latter of these factors were the most persuasive.

The Court observed that the board’s practice of not requiring a public hearing when an ambulance service operating in one area of the state moved to another contradicted the board’s own interpretation of the public hearing requirement, as the board’s regulations “demonstrate[d] the board’s understanding that “ambulance service” in the context of a requirement of public convenience and necessity necessarily connote[d] an area limitation.”<sup>43</sup>

The applicant [for an ambulance service license] is required to publish notice of the hearing in newspapers “serving the proposed service area.” The applicant must present information defining the “proposed service area”; estimating the anticipated volume of service and the proposed response time; and describing other services “presently operating in the proposed service area.” The applicant must also present statements from public officials in the proposed service area indicating that public convenience and necessity require the proposed ambulance service.<sup>44</sup>

The notice-and-comment requirements for ambulance service license applicants, and the regulation’s repeated references to “proposed service areas” greatly strengthened plaintiffs’ case, as they illustrated that the board’s own regulations evinced an understanding that “ambulance service” referred to a particular geographic service area, rather than the entire state.

The Court then analyzed the legislature’s underlying intent and determined that it also favored plaintiffs’ case.

We interpret [MINN. STAT. § 144.802] to manifest a legislative intention to protect the public welfare against deleterious competition in the ambulance services field. The provision embodies a legislative determination that the ambulance service business is one in which the public welfare is not promoted by free

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<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

enterprise. Ambulance service is essential to a community. It is also a service for which demand is inelastic and expenses largely fixed. Where the demand is insufficient to support additional services, either quality is sacrificed or rates and public subsidies increased, but in either event, the taxpayer-consumer suffers.<sup>45</sup>

The Court concluded that it would be illogical to only require a showing of public convenience and necessity at a public hearing for first time ambulance service license applicants given the legislature’s intent to prevent “deleterious competition”, as ambulance service licensees could easily undermine the legislature’s intent by “prov[ing] public necessity and convenience in one area then leav[ing] it to compete in another.”<sup>46</sup>

Consequently, the Court held that the board should not have issued defendants a license to operate an ambulance service in Duluth.<sup>47</sup> The Court also remanded the case to the trial court to determine whether to grant an injunction until such time that defendants could “demonstrate at a public hearing that public convenience and necessity require[d] an additional emergency or nonemergency ambulance service.”<sup>48</sup> Importantly, shortly after the Court’s ruling in the *Twin Ports* case, the state legislature established the primary service area system, where portions of Court’s ruling remain entrenched within the state’s ambulance service licensing procedure to this day.<sup>49</sup>

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<sup>45</sup> *Id.* at 348 (internal citations omitted).

<sup>46</sup> *Id.*

<sup>47</sup> *Id.*

<sup>48</sup> *Id.*

<sup>49</sup> Compare *id.* at 348 (“We interpret [MINN. STAT. § 144.802] to manifest a legislative intention to protect the public welfare against deleterious competition in the ambulance services field. . . .”), with MINN. STAT. § 144E.11(6)(2) (2020) (providing that the EMSRB must consider, among other things, “the deleterious effects on the public health from duplication, if any, of ambulance services that would result from granting the license” when deciding whether to issue an ambulance service license).



## II. Minnesota's EMS Statutes and Regulations

EMS in Minnesota is governed by MINN. STAT. § 144E (titled “Emergency Medical Services Regulatory Board”).<sup>50</sup> Originally, Minnesota’s EMS laws were administered and enforced by the Board of Health, which was abolished and replaced by the Department of Health (“MDH”) in 1977.<sup>51</sup> In turn, MDH was responsible for administering and enforcing the state’s EMS laws until the establishment of the Emergency Medical Services Regulatory Board (“EMS RB”) in 1995.<sup>52</sup> Today, Minnesota’s EMS laws are administered and enforced by the EMS RB.<sup>53</sup> The regulations promulgated by the EMS RB are compiled at MINN. R. 4690.<sup>54</sup>

### A. Emergency Medical Services Regulatory Board

#### 1. Composition

The EMS RB is comprised of the following members who are appointed by the governor: an emergency physician, a representative of hospitals, a representative of fire chiefs, a full-time firefighter who serves as an emergency medical responder, a volunteer firefighter who serves as an emergency medical responder, an attendant currently practicing on a licensed ambulance service who is a licensed paramedic or emergency medical technician, an ambulance service director, a representative of sheriffs, a member of a local board of health, two representatives of

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<sup>50</sup> MINN. STAT. § 144E (2020) (titled “Emergency Medical Services Regulatory Board”).

<sup>51</sup> MINN. STAT. § 144.802 (1977), *repealed by* 1997 Minn. Sess. Law Serv. Ch. 199, Sec. 15) (providing that the Board of Health was responsible for administering and enforcing the state’s ambulance service licensing requirements); MINN. DEP’T OF HEALTH, *supra* note 27 (stating that the Board of Health was abolished and replaced by the Department of Health in 1977).

<sup>52</sup> *EMS RB at a Glance*, EMERGENCY MED. SERVICES REGULATORY BD., <https://mn.gov/emsr/b/about/ataglance> (last visited Feb. 20, 2021) (stating that the EMS RB was established in 1995); *WCCO-TV Channel 4 News*, *supra* note 12 (showing an interview of Department of Health officials as part of an investigative series on ambulance services).

<sup>53</sup> MINN. STAT. § 144E.01(6)(a)(1) (2020) (“The [EMS RB] shall: (1) administer and enforce the provisions of this chapter and other duties as assigned to the board”); MINN. STAT. § 144E.16(4) (“The board may adopt rules needed to regulate ambulance services in the following areas: [listing fifteen aspects of EMS].”); *see also* MINN. STAT. § 144E.05(2) (2020) (“The [EMS RB] may enter into contractual agreements with a person or public or private entity for the provision of statutorily prescribed emergency medical services-related activities by the [EMS RB]. . .”).

<sup>54</sup> MINN. R. 4690 (2013) (titled “Ambulance Services”).

regional EMS programs, a registered nurse currently practicing in a hospital emergency department, a pediatrician, a family practice physician, a public member who resides in Minnesota, the commissioner of the Department of Health or their designee, and the commissioner of the Department of Public Safety or their designee.<sup>55</sup> At least seven of these members must reside outside of the Twin Cities metropolitan area, which includes Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties.<sup>56</sup> Additionally, one state representative and one state senator serve as ex officio, nonvoting members.<sup>57</sup>

## **2. Duties**

The EMSRB's duties are prescribed by MINN. STAT. § 144E.01(6)(a), which provides that the EMSRB shall:

- (1) administer and enforce the provisions of [MINN. STAT. § 144E] and other duties as assigned to the board;
- (2) advise applicants for state or federal emergency medical services funds, review and comment on such applications, and approve the use of such funds unless otherwise required by federal law;
- (3) make recommendations to the legislature on improving the access, delivery, and effectiveness of the state's emergency medical services delivery system; and
- (4) establish procedures for investigating, hearing, and resolving complaints against emergency medical services providers.<sup>58</sup>

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<sup>55</sup> MINN. STAT. § 144E.01(1)(a)(1)–(15) (2020) (listing the EMSRB's members); MINN. STAT. § 144E.01(1)(b) (2020) (“The governor shall appoint members under paragraph (a). Appointments under paragraph (a), clauses (1) to (9) and (11) to (13), are subject to the advice and consent of the senate. In making appointments under paragraph (a), clauses (1) to (9) and (11) to (13), the governor shall consider recommendations of the American College of Emergency Physicians, the Minnesota Hospital Association, the Minnesota and State Fire Chief's Association, the Minnesota Ambulance Association, the Minnesota Emergency Medical Services Association, the Minnesota State Sheriff's Association, the Association of Minnesota Counties, the Minnesota Nurses Association, and the Minnesota chapter of the Academy of Pediatrics.”).

<sup>56</sup> MINN. STAT. § 144E.01(1)(c) (2020) (“At least seven members appointed under paragraph (a) must reside outside of the seven-county metropolitan area, as defined in section 473.121.”); MINN. STAT. § 473.121(2) (2020) (defining “Metropolitan area” as “the counties of Anoka; Carver; Dakota excluding the cities of Northfield and Cannon Falls; Hennepin excluding the cities of Hanover and Rockford; Ramsey; Scott excluding the city of New Prague; and Washington.”).

<sup>57</sup> MINN. STAT. § 144E.01(2) (2020) (“The speaker of the house and the Committee on Rules and Administration of the senate shall appoint one representative and one senator to serve as ex officio, nonvoting members.”).

<sup>58</sup> MINN. STAT. § 144E.01(6)(a)(1)–(4) (2020).



The EMSRB is also authorized, but not required, by MINN. STAT. § 144E.01(6)(b) to “prepare an initial work plan, which may be updated biennially” and “may include provisions to”

- (1) prepare an emergency medical services assessment which addresses issues affecting the statewide delivery system;
- (2) establish a statewide public information and education system regarding emergency medical services;
- (3) create, in conjunction with the Department of Public Safety, a statewide injury and trauma prevention program; and
- (4) designate an annual emergency medical services personnel recognition day.<sup>59</sup>

In administering and enforcing the state’s EMS laws, the EMSRB must regulate both EMS providers and EMS personnel working within Minnesota. First, with respect to EMS providers, the EMSRB enforces state statutes pertaining to ambulance service provider licensing;<sup>60</sup> ambulance service requirements,<sup>61</sup> including equipment standards;<sup>62</sup> air ambulance service provider licensing;<sup>63</sup> and air ambulance service requirements.<sup>64</sup>

Second, with respect to EMS personnel, the EMSRB enforces state statutes pertaining to EMS education programs;<sup>65</sup> EMS instructor qualifications;<sup>66</sup> and licensing for three categories of

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<sup>59</sup> MINN. STAT. § 144E.01(6)(b)(1)–(4) (2020).

<sup>60</sup> See MINN. STAT. § 144E.10(1) (2020) (requiring that all ambulance services operating within the state possess a valid license issued by the EMSRB); MINN. STAT. § 144E.11 (2020) (establishing a licensing procedure for prospective ambulance service providers).

<sup>61</sup> See MINN. STAT. § 144E.101 (2020) (requiring, among other things, that all ambulance services operating within the state are adequately staffed by certified personnel in accordance with the level of ambulance service being provided).

<sup>62</sup> See MINN. STAT. § 144E.103 (2020) (requiring, among other things, that all ambulances operating within the state be equipped with certain basic equipment and additional equipment in accordance with the level of ambulance service being provided).

<sup>63</sup> See MINN. STAT. § 144E.10(1) (2020) (requiring that all ambulance services operating within the state possess a valid license issued by the EMSRB); MINN. STAT. § 144E.12 (2020) (establishing a licensing procedure for prospective air ambulance service providers).

<sup>64</sup> See MINN. STAT. § 144E.121 (2020) (requiring that all air ambulance services operating within the state are compliant with relevant federal and state aviation regulations, staffed by certified personnel in accordance with the level of ambulance service being provided, and equipped in accordance with the level of ambulance service being provided).

<sup>65</sup> See MINN. STAT. § 144E.27 (2020) (requiring, among other things, that all education programs for EMS personnel must be approved by the EMSRB).

<sup>66</sup> See MINN. STAT. § 144E.283 (2020) (specifying that an EMT instructor must satisfy several requirements).

emergency medical responders, including emergency medical technicians (“EMTs”), advanced emergency medical technicians (“AEMTs”), and paramedics (“EMT-Ps”).<sup>67</sup>

## **B. Primary Service Areas**

The most unique component of Minnesota’s EMS laws is the primary service area (“PSA”) requirement.<sup>68</sup> MINN. STAT. § 144E.06 provides that “[t]he [EMSRB] *shall* adopt rules defining primary service areas under which the board *shall* designate each licensed ambulance service as serving a primary service area or areas.”<sup>69</sup> The inclusion of the word “shall” in this statute is legally significant, as the word “shall” in laws and legal documents conveys a command to take or refrain from taking a specified action.<sup>70</sup> In other words, whatever follows the command “shall” is strictly mandatory.<sup>71</sup> Conversely, the use of the word “may” in laws and legal documents conveys that the specified action is discretionary.<sup>72</sup> Thus, the law dictates that the EMSRB *must* define PSAs under which it *must* designate a “licensed ambulance service as serving a primary service area or areas.”<sup>73</sup> Please refer to Hennepin County Primary Service Areas Map, Allina Health EMS Primary Service Areas Map, and Burnsville Fire Department Primary Service Area *infra* Appendix pp. 102–104 for maps illustrating PSAs and an example of a PSA, respectively. The following subsection explains how the state’s ambulance service licensing procedure is inseparable from PSAs.

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<sup>67</sup> See MINN. STAT. § 144E.28 (2020) (specifying, among other things, the requirements to be eligible for certification as an EMT, AEMT, or paramedic by the EMSRB); see also MINN. STAT. § 144E.001 (defining “EMT”, “AEMT”, and “paramedic” for the purposes of state law and regulations).

<sup>68</sup> See MINN. STAT. § 144E.06 (2020) (requiring that the EMSRB establishes primary service areas and designates a licensed ambulance service as serving each primary service area).

<sup>69</sup> MINN. STAT. § 144E.06 (2020) (emphasis added); see also *Ambulance Service Primary Service Area Descriptions*, EMERGENCY MED. SERVICES REGULATORY BD., <https://mn.gov/emsr/ambulanceservices/primary-service-area-description.jsp> (last visited Apr. 25, 2021) (providing a comprehensive database of ambulance service primary service areas in Minnesota).

<sup>70</sup> See *Shall*, BLACK’S LAW DICTIONARY (10th ed. 2014) (defining “shall” as “[h]as a duty to; more broadly, is required to”).

<sup>71</sup> See *id.*

<sup>72</sup> See *May*, BLACK’S LAW DICTIONARY (10th ed. 2014) (defining “may” as “[t]o be permitted to”).

<sup>73</sup> See MINN. STAT. § 144E.06 (2020); BLACK’S LAW DICTIONARY, *supra* note 70 (defining “shall”).

## 1. Ambulance Service Licensing

Ambulance service licenses are fundamentally connected to the ambulance service's PSA, as a ground ambulance service license is required by statute to "specify the base of operations, the primary service area, and the type or types of ambulance service for which the licensee is licensed."<sup>74</sup> An ambulance service licensee must obtain a new license "if it wishes to expand its primary service area, or to provide a new type or types of service."<sup>75</sup> The EMSRB cannot "issue a license authorizing the operation of a new ambulance service, provision of a new type or types of ambulance service by an existing service, or an expanded primary service area for an existing service" unless several statutory requirements are satisfied.<sup>76</sup>

One of these statutory requirements is adherence to the ambulance service licensing procedure prescribed by MINN. STAT. § 144E.11.<sup>77</sup> This procedure requires a prospective ambulance service licensee to submit a written application to the EMSRB.<sup>78</sup> Once the prospective ambulance service licensee has submitted such an application, the EMSRB must notify various stakeholders:

The [EMSRB] shall promptly send notice of the completed application to each county board, community health board, governing body of a regional emergency medical services system designated under [MINN. STAT. § 144E.50], ambulance service, and municipality in the area in which ambulance service would be provided by the applicant. . . .<sup>79</sup>

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<sup>74</sup> MINN. STAT. § 144E.10(1) (2020).

<sup>75</sup> *Id.*

<sup>76</sup> MINN. STAT. § 144E.10(2) (2020) ("The [EMSRB] shall not issue a license authorizing the operation of a new ambulance service, provision of a new type or types of ambulance service by an existing service, or an expanded primary service area for an existing service unless the requirements of this section and [MINN. STAT. §§ 144E.101–144E.127] and [MINN. STAT. § 144E.18] are met.").

<sup>77</sup> *Id.*

<sup>78</sup> MINN. STAT. § 144E.11(1) (2020) ("Each prospective licensee . . . shall make written application for a license to the [EMSRB] on a form provided by the [EMSRB].")

<sup>79</sup> MINN. STAT. § 144E.11(2) (2020).

The EMSRB must also publish notice in the State Register and a local newspaper.<sup>80</sup> In turn, within thirty days of publication of the notice, “[e]ach municipality, county, community health board, governing body of a regional emergency medical services system, ambulance service, and other person wishing to make recommendations concerning the disposition of the application shall make written recommendations or comments opposing the application to the [EMSRB].”<sup>81</sup>

There are detailed procedures for cases in which written comments opposing an application for an ambulance service license are received by the EMSRB.<sup>82</sup> The applicant is exempt from a contested hearing process if the EMSRB receives five or fewer such comments and determines “that the proposed service or expansion of primary service area is needed” after examining four factors that are established by statute.<sup>83</sup> However, the applicant must be given the option of a contested hearing process if the EMSRB receives five or more such comments<sup>84</sup> or “determines that the proposed service or expansion of primary service area is not needed.”<sup>85</sup>

The public hearing must be held “in the municipality in which the applicant’s base of operation is or will be located.”<sup>86</sup> During the hearing, the administrative judge must “allow any interested person the opportunity to be heard, to be represented by counsel, and to present oral and

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<sup>80</sup> *Id.* (“The board shall publish the notice, at the applicant’s expense, in the State Register and in a newspaper in the municipality in which the base of operation is or will be located, or if no newspaper is published in the municipality or if the service is or would be provided in more than one municipality, in a newspaper published at the county seat of the county or counties in which the service would be provided.”).

<sup>81</sup> MINN. STAT. § 144E.11(3) (2020).

<sup>82</sup> *See* MINN. STAT. § 144E.11(4)–(5) (2020).

<sup>83</sup> MINN. STAT. § 144E.11(4)(a) (2020); *see also* MINN. STAT. § 144E.11(6)(1)–(4) (2020) (listing the four factors that the EMSRB must consider in determining whether to approve an ambulance service license application).

<sup>84</sup> MINN. STAT. § 144E.11(5)(a) (2020) (“If more than five written comments opposing the application are received by the [EMSRB] . . . the [EMSRB] shall give the applicant the option of immediately proceeding to a contested case hearing or trying to resolve the objections within 30 days.”).

<sup>85</sup> MINN. STAT. § 144E.11(5)(b) (2020) (“If . . . the [EMSRB] determines that the proposed service or expansion of primary service area is not needed, the [EMSRB] shall give the applicant the option of immediately proceeding to a contested case hearing or using up to 30 days to satisfy the [EMSRB] that the proposed service or expansion of primary service area is needed.”); MINN. STAT. § 144E.11(4)(d) (2020) (“If . . . the [EMSRB] determines that the proposed service or expansion of primary service area is not needed, the case shall be treated as a contested case . . .”).

<sup>86</sup> MINN. STAT. § 144E.11(5)(c) (2020).

written evidence . . . .”<sup>87</sup> Following the hearing, the administrative judge must “review and comment upon the application and make written recommendations as to its disposition to the board” after considering the four statutory factors.<sup>88</sup>

Regardless of whether an ambulance service license application results in a contested or uncontested process, the administrative judge and the EMSRB must consider the following four factors when reviewing the application:

- (1) the recommendations or comments of the governing bodies of the counties, municipalities, community health boards, and regional emergency medical services system designated under [MINN. STAT. § 144E.50] in which the service would be provided;
- (2) the deleterious effects on the public health from duplication, if any, of ambulance services that would result from granting the license;
- (3) the estimated effect of the proposed service or expansion in primary service area on the public health; and
- (4) whether any benefit accruing to the public health would outweigh the costs associated with the proposed service or expansion in primary service area. . . .<sup>89</sup>

Once the administrative judge has reviewed the application and made a recommendation, the EMSRB must review the administrative judge’s report and determine whether to approve the license.<sup>90</sup> The EMSRB’s decision whether to approve the license is the final administrative decision, and aggrieved parties are entitled to judicial review in accordance with MINN. STAT. §§ 14.63–14.69.<sup>91</sup> An ambulance service license is valid for two years from the date of licensure.<sup>92</sup> To renew a license, an ambulance service must submit a renewal application at least

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<sup>87</sup> MINN. STAT. § 144E.11(5)(f)(2) (2020).

<sup>88</sup> MINN. STAT. § 144E.11(5)(g) (2020); *see also* MINN. STAT. § 144E.11(6)(1)–(4) (2020) (listing the four factors that the administrative judge must consider in determining whether to recommend to the EMSRB approval an ambulance service license application).

<sup>89</sup> MINN. STAT. § 144E.11(6)(1)–(4) (2020).

<sup>90</sup> MINN. STAT. § 144E.11(7) (2020).

<sup>91</sup> MINN. STAT. § 144E.11(8) (2020).

<sup>92</sup> MINN. STAT. § 144E.11(9) (2020).

one month prior to the license’s expiration “specifying any changes from the information provided for prior licensure” and pay a fee.<sup>93</sup>

The EMSRB’s approval is also required to transfer an ambulance service license or the ownership of a licensed ambulance service.<sup>94</sup> The EMSRB may only approve such transfers if it finds that “the proposed licensee or proposed new owner of a licensed ambulance service meets or will meet the requirements of [MINN. STAT. §§ 144E.101–144E.127].”<sup>95</sup> Furthermore, “[i]f the proposed transfer would result in an addition of a new base of operations, expansion of the service’s primary service area, or provision of a new type or types of ambulance service, the board shall require the prospective licensee or owner to comply with [the ambulance service licensing procedure under MINN. STAT. § 144E.11].”<sup>96</sup> The following subsections explain how additional statutory and regulatory provisions govern PSAs.

## **2. Modifications of PSAs**

MINN. STAT. § 144E.07 provides several additional statutory parameters regarding PSAs.<sup>97</sup>

First, with respect to the expansion of PSAs, an ambulance service may request to expand its PSA to encompass a “contiguous, but undesignated” PSA:

An ambulance service may request a change in its primary service area, as established under [MINN. STAT. § 144E.06], to eliminate any overlap in primary service areas or to expand its primary service area to provide service to a contiguous, but undesignated, primary service area. An ambulance service requesting a change in its primary service area must submit a written application to the board on a form provided by the board and must comply with the requirements of this section.<sup>98</sup>

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<sup>93</sup> *Id.*; see also MINN. STAT. § 144E.29 (2020) (setting fee amounts for the various licenses issued by the EMSRB).

<sup>94</sup> MINN. STAT. § 144E.14 (2020).

<sup>95</sup> *Id.*

<sup>96</sup> *Id.* (emphasis added).

<sup>97</sup> See MINN. STAT. § 144E.07 (2020) (addressing expansion, overlap, and retraction of primary service areas).

<sup>98</sup> MINN. STAT. § 144E.07(1) (2020).

Second, with respect to retraction, an ambulance service cannot terminate service within a portion of its PSA without another licensed ambulance service taking responsibility for the area in question:

An applicant requesting to retract service from a geographic area within its designated primary service area must provide documentation showing that another licensed ambulance service is providing or will provide ambulance coverage within the proposed area of withdrawal.<sup>99</sup>

Third, with respect to overlapping expansion, an ambulance service cannot expand its PSA into the PSA of a second ambulance service without the second ambulance service terminating service for the area in question:

An applicant requesting to provide service in a geographic area that is within the primary service area of another licensed ambulance service or services must submit documentation from the service or services whose primary service areas overlap the proposed expansion area, approving the expansion and agreeing to withdraw any service coverage from the proposed expanded area. The application may include documentation from the public safety answering point coordinator or coordinators endorsing the proposed change.<sup>100</sup>

Fourth, with respect to areas with no designated primary ambulance service:

An applicant requesting to provide service in a geographic area where no primary ambulance service has been designated must submit documentation of approval from the ambulance service or services which are contiguous to the proposed expansion area. The application may include documentation from the public safety answering point coordinator or coordinators endorsing the proposed change. If a licensed ambulance service provides evidence of historically providing 911 ambulance coverage to the undesignated area, it is not necessary to provide documentation from the contiguous ambulance service or services approving the change. At a minimum, a 12-month history of primary ambulance coverage must be included with the application.<sup>101</sup>

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<sup>99</sup> MINN. STAT. § 144E.07(2) (2020).

<sup>100</sup> MINN. STAT. § 144E.07(3) (2020).

<sup>101</sup> MINN. STAT. § 144E.07(4) (2020).

Fifth, the EMSRB “shall report any approved change [in primary service areas] to the local public safety answering point coordinator.”<sup>102</sup>

### **3. Additional PSA Regulations**

The EMSRB has also promulgated administrative regulations that govern PSAs.<sup>103</sup> The first portion of these rules establishes basic requirements for PSA applications, which stipulates that the ambulance service license applicant must possess a base of operation within the PSA:

An applicant for a new license, for a change in type of service or base of operation, or for expansion of a primary service area must declare the primary service area that it intends to serve and seek designation of that area. A primary service area must contain one base of operation and may contain substations.<sup>104</sup>

The second portion of these rules establishes “reasonableness” requirements that a PSA applicant must satisfy:

In applying for initial designation of a primary service area or for expansion of a primary service area, an applicant must show the reasonableness of the primary service area for which designation is sought according to the following considerations:

- (A) the average and maximum probable response times in good and severe weather from its proposed base of operation to the most distant boundary in its proposed primary service area; or, if the applicant's primary service area is to contain a base of operation and substations, the average and maximum probable response times in good and severe weather from the base of operation and substations to the most distant point covered by the base of operation;
- (B) the projected distances to be traveled to provide such service;
- (C) the specific type of service to be provided;
- (D) the applicant's current status as a licensed provider of ambulance services to the population of that area; and
- (E) the applicant's intention to be responsible to the population of the declared primary service area or to a specified group of persons as a source of ambulance service.<sup>105</sup>

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<sup>102</sup> MINN. STAT. § 144E.07(5) (2020).

<sup>103</sup> See MINN. R. 4690.3400 (2013).

<sup>104</sup> MINN. R. 4690.3400(1) (2013).

<sup>105</sup> MINN. R. 4690.3400(2) (2013).



The third portion of these rules establishes geographical limitations on PSAs, which are based on the PSA's size as measured by distance in miles or travel time in minutes from the ambulance service's base of operations or substation. These limits are also dictated by whether the PSA encompasses a city of the first<sup>106</sup> or second<sup>107</sup> class:

The maximum primary service areas designated, as measured from a base of operation or substation, may not exceed:

- (A) eight miles or ten minutes travel time at maximum allowable speeds, whichever is greater, for proposed primary service areas that include any portion of a city of the first class;
- (B) 15 miles or 20 minutes travel time at maximum allowable speeds, whichever is greater, for proposed primary service areas that include any portion of a city of the second class; or
- (C) 25 miles or 30 minutes travel time at maximum allowable speeds, whichever is greater, for proposed primary service areas that do not include any portion of a city of the first or second class.<sup>108</sup>

The geographic limitations on PSAs do not apply to air ambulance service providers.<sup>109</sup> In fact, air ambulance service providers are exempt from the ambulance service licensing procedure under MINN. STAT. § 144E.11, and air ambulance service licenses “need not designate a primary service area.”<sup>110</sup>

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<sup>106</sup> See MINN. STAT. § 410.01 (2020) (defining a city of the first class as “[t]hose having more than 100,000 inhabitants”).

<sup>107</sup> See MINN. STAT. § 410.01 (2020) (defining a city of the second class as “[t]hose having more than 20,000 and not more than 100,000 inhabitants”).

<sup>108</sup> MINN. R. 4690.3400(3) (2013).

<sup>109</sup> MINN. R. 4690.3600 (2013).

<sup>110</sup> MINN. STAT. § 144E.12 (2020) (“Except for submission of a written application to the board on a form provided by the board, an application to provide air ambulance service shall be exempt from the provisions of [MINN. STAT. § 144E.11]. A license issued pursuant to this section need not designate a primary service area. No license shall be issued under this section unless the board determines that the applicant complies [MINN. STAT. §§ 144E.10, 144E.11(1), 144E.121–144E.127, and 144E.18] and the requirements of applicable federal and state statutes and rules governing aviation operations within the state.”).

### C. Antitrust Implications of Minnesota’s EMS Laws

The Sherman Antitrust Act of 1890 (“Sherman Act”), 26 Stat. 209, 15 U.S.C. §§ 1–7, provides that a state cannot adopt laws or regulations that improperly restrict competition. In other words, the Sherman Act prescribes a rule of free competition, as Section 1 provides that “[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.”<sup>111</sup> Section 2 two declares that it is unlawful to “monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations . . . .”<sup>112</sup>

However, federal antitrust laws do not apply to states acting in their sovereign capacities under the United States Supreme Court case of *Parker v. Brown*.<sup>113</sup> This exemption from liability under federal antitrust law is known as the Parker Doctrine, and it is based on the principles of federalism and state sovereignty.<sup>114</sup> In short, the Sherman Act was intended to prohibit private restraints on trade, and was not intended to “restrain state action or official action directed by a state.”<sup>115</sup> State action immunity also applies to private persons and corporations when their action constitutes “official action directed by a state.”<sup>116</sup> Notably, state action immunity applies to other federal antitrust statutes as well as the Sherman Act.<sup>117</sup>

State action immunity under the Parker Doctrine is extended to political subdivisions, including cities and counties, when such entities are acting “pursuant to a clearly articulated state

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<sup>111</sup> 15 U.S.C. § 1 (2004).

<sup>112</sup> 15 U.S.C. § 2 (2004).

<sup>113</sup> *Parker v. Brown*, 317 U.S. 341, 350 (1943).

<sup>114</sup> *Id.* at 350–51.

<sup>115</sup> *Id.* at 351.

<sup>116</sup> *Id.*

<sup>117</sup> *See generally* 1 Antitrust Laws and Trade Regulation: Desk Edition § 6.02 (2020) (citing various federal cases expanding state action immunity to other antitrust statutes).

policy.”<sup>118</sup> Importantly, the statute articulating the state policy does not need to state explicitly that it intends to displace competition if anticompetitive effects are the foreseeable result. For example, the foreseeable result standard was satisfied in a zoning regulation where “the very purpose of the regulation [was] to displace unfettered business freedom in a manner that regularly has the effect of preventing normal acts of competition.”<sup>119</sup>

State agencies and commissions created by the legislature are also exempt from antitrust liability under the Parker Doctrine if they are acting pursuant to a clearly articulated state policy.<sup>120</sup> This includes a commission established by statute, despite the involvement of private parties.<sup>121</sup> One example of the application of this “clearly articulated state policy” standard in the Eighth Circuit, which includes Minnesota, affirmed immunity under the Parker Doctrine when a statutorily-established state board of dental examiners issue[d] medical regulations that may have had anticompetitive effects on denture construction.<sup>122</sup> The “clearly articulated state policy standard” is also met by commissions where statutes demonstrate that rate setting was sanctioned by the legislature.<sup>123</sup>

To enjoy immunity under the Parker Doctrine, a municipality must demonstrate that anticompetitive activities were authorized by the state pursuant to a clearly articulated state policy intended to displace competition with regulation or monopoly public service.<sup>124</sup> This is typically satisfied when statutes authorize a municipality to regulate a particular area. For example, the U.S.

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<sup>118</sup> *Hallie v. City of Eau Claire*, 471 U.S. 34, 40 (1985).

<sup>119</sup> *City of Columbia v. Omni Outdoor Advert.*, 499 U.S. 365, 373 (1991).

<sup>120</sup> *But see* *Charley’s Taxi Radio Dispatch v. SIDA of Haw., Inc.*, 810 F.2d 869, 873 (9th Cir. 1987); *Traffic Jam & Snug, Inc. v. Michigan Liquor Control Comm’n*, 1990-1 Trade Cas. (CCH) 68,996 (6th Cir. 1990) (demonstrating that the Ninth and Sixth Circuits, respectively, have decided that agencies are equal to the sovereign and that state action immunity under the Parker Doctrine is automatic).

<sup>121</sup> *Parker v. Brown*, 317 U.S. 341, 352 (1943).

<sup>122</sup> *Brazil v. Arkansas State Bd. Dental Examiners*, 759 F.2d 674 (8th Cir. 1985).

<sup>123</sup> *S. Motor Carriers Rate Conference v. United States*, 471 U.S. 48, 63 (1985).

<sup>124</sup> *Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 413 (1978).

Supreme Court has stated in the context of sewage services that “[i]t is sufficient that the statutes authorized the City to provide sewage services and also to determine the areas to be served. We think it is clear that anticompetitive effects logically would result from this broad authority to regulate.”<sup>125</sup>

However, a municipality is less likely to enjoy immunity under the Parker Doctrine when it acts within broader grants of authority. For example, the “clearly articulated state policy standard” was not satisfied when a municipality was regulating cable television services under authority of a statute that simply did not address the regulation of cable television.<sup>126</sup> This standard was not satisfied in another case in which a state had not articulated a policy to allow a public hospital authority to engage in a merger that raised Clayton Act competitive activity concerns.<sup>127</sup> In that case, the state had merely granted neutrality on the matter by giving cities and counties general powers “routinely conferred upon private corporations.”<sup>128</sup>

Simply put, Minnesota’s highly centralized EMS system likely falls the Parker Doctrine. The primary service areas created by MINN. STAT. § 144E.06 expresses the legislature’s clear intention to displace competition for the provision of EMS in the state.<sup>129</sup> This articulated state policy also expresses a clear intent to delegate licensing and regulation of anticompetitive PSAs to the EMSRB, which likely satisfies the relevant legal standard to extend state action immunity to a state agency. Notably, there are also circuit court decisions that affirm the local control model of furnishing EMS satisfies the Parker Doctrine.<sup>130</sup>

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<sup>125</sup> *Hallie v. City of Eau Claire*, 471 U.S. 34, 42 (1985).

<sup>126</sup> *Cnty. Communications Co. v. City of Boulder*, 455 U.S. 40 (1982).

<sup>127</sup> *FTC v. Phoebe Putney Health Sys.*, 568 U.S. 216, 217 (2013).

<sup>128</sup> *Id.*

<sup>129</sup> See MINN. STAT. § 144E.06; see also *Twin Ports Convalescent, Inc. v. Minn. State Bd. of Health*, 257 N.W.2d 343 (Minn. 1977).

<sup>130</sup> *W. Star Hosp. Auth., Inc. v. City of Richmond*, 986 F.3d 354, 358 (4th Cir. 2021); *AmeriCare MedServices, Inc. v. City of Anaheim*, 735 F. App’x 473, 474 (9th Cir. 2018).

Minnesota also has a state antitrust law that prohibits the actual or attempted “establishment, maintenance, or use of . . . monopoly power over any part of trade or commerce by any person or persons for the purpose of affecting competition or controlling, fixing, or maintaining prices.”<sup>131</sup> But Minnesota law also contains an explicit provision exempting state action, which states “[n]othing contained in [MINN. STAT. §§ 325D.49 – 325D.66], shall apply to actions or arrangements otherwise permitted, or regulated *by any regulatory body or officer acting under statutory authority of this state* or the United States.”<sup>132</sup> Therefore, Minnesota’s EMS regulatory system is likely exempt on the grounds that the EMSRB operates under the statutory authority of the state.

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<sup>131</sup> MINN. STAT. § 325D.52 (2020).

<sup>132</sup> MINN. STAT. § 325D.55(2)(a) (2020) (emphasis added).



### **III. Comparison of Minnesota’s Primary Service Area Statute to Other States**

This section is divided into three subsections to make the information contained herein as accessible as possible. Section III.A provides an abbreviated overview of the basic features of state EMS statutes and regulations. Section III.B provides a summary of key themes in state EMS systems, including ambulance provider service areas, state oversight and regional delegation, local input and control, and comprehensive planning. Section III.C provides a survey of each state’s EMS statutes and regulations. Please refer to Table: State-by-State Summary of EMS Systems *infra* Appendix p. 101 for a concise picture of state EMS systems in the United States.

#### **A. Basic Features of EMS Statutes and Regulations**

The details of EMS statutes and regulations vary significantly across the United States, leading to the adage that “when you have seen one EMS system, you have seen one EMS system.” The remarkable variety of EMS systems reflects the unique climate, history, geography, politics, and population distributions of different states, as well as the relative infancy of EMS as a profession.<sup>133</sup> However, while the details of EMS systems vary substantially from state-to-state, there are some basic commonalities. For example, every state requires that EMS providers obtain a license,<sup>134</sup> although many states, including Minnesota,<sup>135</sup> provide exceptions for extraordinary circumstances, such as major catastrophes.<sup>136</sup> Additionally, every state establishes an entity that is responsible for administering and enforcing the state’s EMS statutes and regulations, such as a state agency, board, or committee. However, not every state’s laws and regulations dictate how

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<sup>133</sup> See The History of EMS in Minnesota *supra* Section I pp. 3–11.

<sup>134</sup> See, e.g., MINN. STAT. § 144E.10(1) (“No natural person, partnership, association, corporation, or unit of government may operate an ambulance service within this state unless it possesses a valid license to do so issued by the board. . .”).

<sup>135</sup> MINN. STAT. § 144E.266 (2020).

<sup>136</sup> See, e.g., MO. REV. STAT. § 190.105(3)(1) (“No license shall be required for an ambulance service, or for the attendant of an ambulance, which: [] Is rendering assistance in the case of an emergency, major catastrophe or any other unforeseen event or series of events which jeopardizes the ability of the local ambulance service to promptly respond to emergencies”).

service areas must be allocated to ambulance service providers, and those that do vary greatly in their approaches to the issue.<sup>137</sup>

## **B. Summary of Key Themes Across State EMS Statutes and Regulations**

It is exceedingly difficult, if not impossible, to truly “categorize” every state into types of EMS systems, as states have adopted so many different models for regulating EMS and allocating ambulance provider service areas. As the nationwide survey, no two states are the same; however, there are some broad trends regarding ambulance provider service areas, state oversight and regional delegation, local input and control, and comprehensive statewide planning.

### **1. Ambulance Provider Service Areas**

Minnesota’s EMS system is extraordinary in how it allocates service areas for ambulance service providers, as most states do not employ a system that requires granting ambulance providers exclusive service areas. In fact, Minnesota and Connecticut are the only two states that explicitly require a state regulatory authority to establish service areas and assign a single ambulance service provider to each one. Connecticut’s system is also significantly more robust than Minnesota’s system, as Connecticut affords to local communities and regional EMS entities a mechanism through which they can petition the state agency tasked with allocating EMS service areas to revoke an ambulance service provider’s service area assignment when necessary to protect public health and safety.

Other states have statutory requirements that bear a passing resemblance to Minnesota’s but contain substantial differences. For example, in Utah, the Department of Health creates a statewide system that consists of exclusive ambulance service areas. However, Utah law provides for local oversight of the ambulance service licensing process, as providers must be selected, and

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<sup>137</sup> See Table: State-by-State Summary of EMS Systems *infra* Appendix p. 103.



contracts awarded, by political subdivisions. Utah also permits the creation of maximum rates for ambulance services. Vermont's EMS system also includes PSA designations, but ambulance services may only be licensed if they comply with response plans developed by the EMS district board in conjunction with municipal officials.

Other states require a state regulatory authority to license ambulance services by geographic service areas, but do not necessarily assign a single ambulance service to each one, meaning multiple ambulance services may be permitted to furnish EMS in the same service area. For example, in Arizona, ambulance services must obtain a "certificate of necessity" to operate in a particular service area, but state law provides that multiple providers can serve a single service area, and there are substantial rate restrictions on EMS providers. Florida utilizes a similar system, albeit without extensive statutory rate control.

In California, local EMS authorities may submit plans to the state EMS authority for approval that include exclusive operating areas for certain ambulance service providers, but such exclusive operating areas may only be allocated through a competitive process. In Idaho, ambulance services simply declare their own geographic coverage area(s) in their ambulance service license application. Additional states, like Georgia and Mississippi, require ambulance service license applicants to specify their intended service areas, but do not restrict ambulance service licensees geographically.

## **2. Local Input and Control**

Minnesota's EMS system is also unusual in how it provides effectively no meaningful opportunities for local input and control over EMS. Again, even Minnesota's closest EMS system peer, Connecticut, offers significantly more robust statutory and regulatory procedures for local input and control. Notably, other states characterized by limited local control, like Washington,

are generally focused on maintaining stringent and comprehensive statewide EMS plans. Meanwhile, Massachusetts, which requires regional EMS councils to adopt “service zone plans” and prohibits ambulance services from providing primary response in an area if not designated as the “primary ambulance service”, nevertheless requires a selection process carried out by a local jurisdiction.

Some states go even further, and explicitly provide that local political subdivisions are legally entitled to establish their own EMS systems or furnish EMS to their communities. For example, in Michigan, local governments (or combinations of local governments) are empowered to furnish EMS or contract with an entity to furnish EMS to their communities. Arkansas, Indiana, and Kansas also permit city or county governments to establish their own EMS systems. North Carolina and West Virginia are similar.

There are also states such as Oregon, in which counties must develop plans that are approved at the state level. In Texas, an ambulance service may only be licensed if it obtains a letter of approval from the municipality or county in which it seeks to provide service. Many states also provide that municipalities may restrict ambulance services by enacting ordinances or regulations that are stricter than those at the state, so long as they do not conflict with state law or regulations.

### **3. State Oversight and Regional Delegation**

Minnesota’s EMS system is also extraordinary in that the state’s EMS system is governed and overseen by a single, state-level entity, the EMSRB as most states have multiple entities involved in the administration and enforcement of EMS laws and regulations, including advisory committees, councils, and commissions. For example, in Mississippi, the Board of Health promulgates rules, which are informed and recommended by an advisory council, and

subsequently enforced by state agencies. Many states implement also implement system for regulating EMS services that divides the state into districts or regions. Examples of states that use EMS districts or regions include Illinois, Missouri, Oklahoma, Ohio, New Hampshire, New York, North Carolina, Oregon, Pennsylvania, Texas, and Virginia. Minnesota's EMS system is also centralized at the state level in the EMSRB. Many states that operate a similar "top down" EMS system have other state-level boards or committees for the purposes of accountability, advising, oversight, and planning, such as Montana, Nebraska, and Wisconsin.

#### **4. Comprehensive Statewide Planning**

The EMS system in some states is centered around a comprehensive and unified statewide plan. States with comprehensive plans often include local input, regional allocation, and many other factors in determining ambulance provider service areas and developing local EMS systems. Most of these systems are relatively new and were selected to reform an older EMS system. For example, Pennsylvania operates a statewide plan which includes guiding and coordinating programs for efficient operation of statewide and regional EMS systems. The plan includes coordinating providers and assisting local governments and is implemented through regional councils, which also must prepare regional plans. Virginia also develops one statewide and multiple regional plans. The plan details the primary service area for providers and responding interval standards that have been approved by the local government and the operational medical director.<sup>138</sup> Texas also requires statewide and EMS delivery area plans.<sup>139</sup> Alaska and Hawaii also utilize similar statewide plans, which is likely a reflection of the unique characteristics of both states.

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<sup>138</sup> 12 Va. Admin. Code § 5-31-10 (Lexis Advance through April 1, 2021).

<sup>139</sup> Tex. Health & Safety Code § 773.023 (LexisNexis, Lexis Advance through the most recent legislation which is the 2019 Regular Session, 86th Legislature, and the 2019 election results).

## C. State-by-State Survey of EMS Statutes and Regulations

### 1. Alabama

EMS in Alabama is governed by ALA. CODE § 22-18 *et seq.* (titled “Ambulances and Emergency Medical Services”).<sup>140</sup> Alabama’s EMS laws are administered and enforced by the Board of Health (“Board”)<sup>141</sup> through the Office of Emergency Medical Services (“OEMS”) within the Department of Public Health (“Department”).<sup>142</sup> The Emergency Medical Control Committee (“Committee”) is responsible for assisting the Board in formulating policies and rules pertaining to EMS.<sup>143</sup> The Committee is comprised of various medical professionals who are appointed by their respective professional associations.<sup>144</sup>

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<sup>140</sup> ALA. CODE § 22-18 *et seq.* (titled “Ambulances and Emergency Medical Services”). Please note that all citations to ALA. CODE § 22-18 *et seq.* herein are current through Acts 2021-174, Acts 2021-177 through 2021-182, Acts 2021-184, 2021-186, 2021-187, 2021-189 through 2021-193, and 2021-195 through 2021-199 (Westlaw Edge).

<sup>141</sup> ALA. CODE § 22-18-3(a) (“In the manner provided in this section, the Board of Health shall establish and publish reasonable rules and regulations for the training, qualification, scope of privilege, and licensing of EMSP, and provider services, and for the operation, design, equipment, and licensing of air and ground ambulances. . . .”).

<sup>142</sup> See ALA. ADMIN. CODE r. 420-2-1.11(1) (2020) (“No person shall operate an emergency medical provider service until obtaining a license. All emergency medical provider service licenses are issued by the OEMS under the authority of the Board. . . .”).

<sup>143</sup> ALA. CODE § 22-18-40(a) (“The board shall be assisted in formulating rules and policy pertaining to emergency medical services by the State Emergency Medical Control Committee (SEMCC). . . .”).

<sup>144</sup> ALA. CODE § 22-18-40(b) (“The SEMCC shall be composed as follows: (1) The medical directors of each EMS region designated by the board as ex officio members. (2) One member who shall be a physician appointed by the Alabama Chapter of the American College of Emergency Physicians. (3) One member who shall be a physician appointed by the State Committee on Trauma of the American College of Surgeons. (4) One member who shall be a physician appointed by the Alabama Chapter of the American Academy of Pediatrics. (5) The State EMS Medical Director, as an ex officio member, who shall serve as its chair. (6) The State Trauma Consultant if a physician is designated as such by the Board of Health or pursuant to other procedure established by law as an ex officio member. (7) One member who shall be an Alabama physician appointed by the Alabama Chapter of the Association of Air Medical Services. (8) One member who shall be a physician appointed by the Alabama Hospital Association. (9) One member who shall be a paramedic licensed in this state appointed by the Alabama Ambulance Association. (10) One member who shall be a paramedic licensed in this state appointed by the Alabama Association of Rescue Squads. (11) One member who shall be a paramedic licensed in this state appointed by the Alabama Emergency Medical Services Association. (12) One member who shall be a paramedic licensed in this state appointed by the Alabama Chapter of the Association of Air Medical Services. (13) One member who shall be a paramedic licensed in this state appointed by the Professional Firefighters of Alabama. (14) One member who shall be a paramedic licensed in this state appointed by the Alabama Association of Volunteer Fire Departments. (15) One member who shall be a paramedic licensed in this state appointed by the Alabama Association of Fire Chiefs. (16) One member who shall be a paramedic licensed in this state appointed by the Alabama Firefighters Association. (17) One member who shall be an educator involved in the development or instruction of an EMS training and education program at an Alabama Community College System (ACCS) institution appointed by the State EMS Medical Director. (18) Two physicians appointed by the Medical Association of the State of Alabama.”).

Alabama, like the many states, issues EMS provider licenses by the category of service: ALS transport (ground or air), ALS non-transport, or BLS transport.<sup>145</sup> EMS provider licenses must be renewed<sup>146</sup> and are nontransferable.<sup>147</sup> Regulations provide that the Board issues EMS providers such licenses on a county-by-county basis:

Each licensed emergency medical provider service shall obtain a separate license for each county in which a ground ambulance, or service area in which an air ambulance, is based. The license shall be displayed in a conspicuous place in the emergency medical provider's main office in the county or service area.<sup>148</sup>

EMS provider licenses may also carry a “24/7/365” hours of service requirement depending on the category of service:

Within 60 calendar days of receipt from the State Board of Health of its initial (first) license to operate as a provider service from a base within a ground provider's licensed county or an air provider's licensed service area, each licensed provider service shall be in continuous operation in the county in which it is licensed, providing emergency response 24 hours a day, 7 days a week, 365 days a year. ALS Non-Transport services are exempt from this requirement.<sup>149</sup>

BLS non-transport services, including those furnished by volunteer fire departments, are also exempt from this requirement.<sup>150</sup> Interestingly, regulations specifically prohibit EMS providers from “[s]elf-dispatch[ing] or caus[ing] a vehicle to be dispatched on a call in which another provider service has been dispatched.”<sup>151</sup>

Alabama’s EMS statutes and regulations do not indicate that EMS provider licenses are contingent (in whole or in part) on a determination that issuing the license is necessary for public

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<sup>145</sup> ALA. ADMIN. CODE r. 420-2-1.11(2).

<sup>146</sup> ALA. ADMIN. CODE r. 420-2-1.11(6).

<sup>147</sup> ALA. ADMIN. CODE r. 420-2-1.11(8).

<sup>148</sup> ALA. ADMIN. CODE r. 420-2-1.11(7).

<sup>149</sup> ALA. ADMIN. CODE r. 420-2-1.11(9).

<sup>150</sup> ALA. CODE § 22-18-44 (“Neither the provisions of this chapter nor rules of the board adopted thereunder shall apply to volunteer fire departments which are not regularly engaged in the provision of emergency medical care and which offer only Basic Life Support response and do not transport. . .”).

<sup>151</sup> ALA. ADMIN. CODE r. 420-2-1.11(12)(b).

benefit, as Minnesota requires.<sup>152</sup> Thus, local political subdivisions are free to furnish EMS for their constituents or contract with an EMS provider to furnish such services. This also means that EMS providers may furnish services in an area so long as they first receive the appropriate license.

## 2. Alaska

EMS in Alaska is governed by ALASKA STAT. § 18.08 *et seq.* (titled “Emergency Medical Services”).<sup>153</sup> Alaska’s EMS laws are administered and enforced by the Department of Health and Social Services (“Department”).<sup>154</sup> The Council on Emergency Medical Services (“Council”), which is an entity within the Department, is responsible for advising the Department on planning and implementing a statewide EMS system.<sup>155</sup> The Council is comprised of various medical professionals who are appointed by the governor.<sup>156</sup>

Alaska’s EMS statute dictates that the state utilizes a comprehensive statewide EMS system, under which the Department must:

- (1) coordinate public and private agencies engaged in the planning and delivery of emergency medical services, including trauma care, to plan an emergency medical services system;
- (2) assist public and private agencies to deliver emergency medical services, including trauma care, through the award of grants in aid;

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<sup>152</sup> See MINN. STAT. § 144E.11(6)(1)–(4) (2020) (listing the four factors that the EMSRB must consider in determining whether to approve an ambulance service license application).

<sup>153</sup> ALASKA STAT. § 18.08 *et seq.* (titled “Emergency Medical Services”). Please note that all citations to ALASKA STAT. § 18.08 *et seq.* herein are current with legislation through Chapter 32 and Ballot Measure 2 of the 2020 Second Regular Session of the 31st Legislature (Westlaw Edge).

<sup>154</sup> ALASKA STAT. § 18.08.010 (“The department is responsible for the development, implementation, and maintenance of a statewide comprehensive emergency medical services system . . . .”); ALASKA STAT. § 18.08.200(5) (2016) (defining “department” as “the Department of Health and Social Services”).

<sup>155</sup> ALASKA STAT. § 18.08.020.

<sup>156</sup> ALASKA STAT. § 18.08.030 (“The council consists of 11 members appointed by the governor. The governor shall provide for appropriate geographical distribution in the appointments and shall appoint (1) two members who are physicians with experience in emergency medicine or trauma care; (2) one member who is a registered nurse with experience in emergency nursing; (3) three members who are active as prehospital emergency care providers, at least one of whom resides in a community that is not connected by land or marine highway, or a combination of land and marine highway, to a community in which a hospital is located; . . . (4) one member who is an emergency medical services administrator; (5) one member who is an administrator of a hospital or Native health care organization; and (6) three members who are consumers of emergency medical services who each reside in a different judicial district in the state.”).

- (3) conduct, encourage, and approve programs of education and training designed to upgrade the knowledge and skills of health personnel involved in emergency medical services, including trauma care;
- (4) establish and maintain a process under which hospitals and clinics could represent themselves to be trauma centers because they voluntarily meet criteria adopted by the department; criteria adopted by the department to implement this paragraph must be based on an applicable national evaluation system.<sup>157</sup>

Alaska appears to determine EMS provider service areas as part of a comprehensive statewide plan. Notably, Alaska's extreme climate and geography present arguably the most demanding challenges for EMS providers, fire departments, and law enforcement agencies than those found anywhere else in the country.

### **3. Arizona**

EMS in Arizona is governed by ARIZ. REV. STAT. § 36-21.1 *et seq.* (titled "Emergency Medical Services").<sup>158</sup> Arizona's EMS laws are administered and enforced by the Department of Health Services ("Department").<sup>159</sup> There are three subgroups that are responsible for recommending various "standards and criteria that pertain to the quality of emergency patient care" to the Department: (1) the medical director of the statewide Emergency Medical Services and Trauma System ("EMSTS"), which is a division of the Department; (2) the Emergency Medical Services Council ("Council"), which is a group of professionals appointed to assist the Department in developing EMS training protocols; and (3) the Medical Direction Commission ("Commission"), which is a group of physicians appointed to assist the Department in developing EMS treatment protocols.<sup>160</sup>

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<sup>157</sup> ALASKA STAT. § 18.08.010.

<sup>158</sup> ARIZ. REV. STAT. § 36-21.1 *et seq.* (titled "Emergency Medical Services"). Please note that all citations to ARIZ. REV. STAT. § 36-21.1 *et seq.* herein are current through legislation effective Apr. 9, 2021 of the First Regular Session of the Fifty-Fifth Legislature (2021) (Westlaw Edge).

<sup>159</sup> See ARIZ. REV. STAT. § 36-2202(A).

<sup>160</sup> ARIZ. REV. STAT. § 36-2204.

Arizona law provides that “[a]ny person wishing to operate an ambulance service in [the] state shall apply to the department . . . for a certificate of necessity.”<sup>161</sup> Certificates of necessity describe the ambulance service’s service area, level of service, and type of service, among other things.<sup>162</sup> The Department *must* issue a certificate of necessity if: (1) the ambulance service has a certificate of registration issued by the Department for at least one ambulance; (2) the Department finds that public necessity requires the service or any part of the service proposed by the applicant; (3) the Department finds that the applicant is fit and proper to provide the service; (4) the applicant has paid an appropriate fee; and (5) the applicant has filed a surety bond.<sup>163</sup> Public hearings are required for proposed actions related to certificates of necessity, among other things.<sup>164</sup>

Initial certificates of necessity are issued for a term of one year.<sup>165</sup> If an ambulance service meets all the requirements for renewal, the Department must renew the certificate of necessity for a term of three years without a public hearing.<sup>166</sup> The law explicitly specifies that certificates of necessity are not franchises, as they may be revoked by the Department and do “not confer a property right on its holder.”<sup>167</sup> Additionally, certificates of necessity cannot be assigned or transferred without written approval of the Department.<sup>168</sup> The Department may also suspend a

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<sup>161</sup> ARIZ. REV. STAT. § 36-2233(A).

<sup>162</sup> ARIZ. REV. STAT. § 36-2201(11)(a)–(h).

<sup>163</sup> ARIZ. REV. STAT. § 36-2233(B).

<sup>164</sup> ARIZ. REV. STAT. § 36-2234(A) (“The director shall require a public hearing on any proposed action related to rates, fares or charges, operating or response times, bases of operation or certificates of necessity unless subsection C, E, or M of this section applies.”).

<sup>165</sup> ARIZ. REV. STAT. § 36-2235(A) (“The initial certificate of necessity issued pursuant to § 36-2233 to each ambulance service shall be for a term of one year.”).

<sup>166</sup> ARIZ. REV. STAT. § 36-2235(B) (“On the expiration of a certificate of necessity, if the holder of the certificate meets all requirements, applies for a renewal and pays the fees prescribed in § 36-2240, the director shall renew the certificate for a term of three years without public hearing or waiver unless cause is shown to set a hearing to consider denial or renewal for a shorter term.”).

<sup>167</sup> ARIZ. REV. STAT. § 36-2236(A) (“A certificate of necessity issued pursuant to this article is not a franchise, may be revoked by the director and does not confer a property right on its holder.”).

<sup>168</sup> ARIZ. REV. STAT. § 36-2236(B) (“A certificate of necessity shall not be assigned or otherwise transferred without the written approval of the director. When any certificate is assigned or transferred, the director shall issue to the assignee or transferee a new certificate valid only for the unexpired term of the transferred or assigned certificate.”).



certificate of necessity “[i]n the case of an emergency” by following administrative procedures required by statute.<sup>169</sup> It is unclear exactly what would constitute an “emergency” sufficient to invoke this provision, as there are no regulations or case law that address the question. The law also dictates that an ambulance service authorized to operate under a certificate of necessity cannot simply terminate service.<sup>170</sup>

Arizona’s EMS statutes and regulations do not indicate that a certificate of necessity grants EMS providers *exclusive* operations within their service area. In fact, the Department may establish uniform rates and charges for a service area “[i]f all ambulance services that have been granted authority to operate within the same service area or that have overlapping certificates of necessity apply for uniform rates and charges.”<sup>171</sup> EMS providers are also assigned rates and charges by the Department.<sup>172</sup>

#### 4. Arkansas

EMS in Arkansas is governed by ARK. CODE § 20-13 *et seq.* (titled “Emergency Medical Services”).<sup>173</sup> Arkansas’ EMS laws are administered and enforced by Board of Health (“Board”) through the Division of Emergency Medical Services (“Division”) within the Department of Health (“Department”).<sup>174</sup> The Emergency Medical Services Advisory Council (“Council”) is

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<sup>169</sup> ARIZ. REV. STAT. § 36-2236(C) (“In case of emergency, the director may suspend a certificate of necessity as provided in § 36-2234.”).

<sup>170</sup> ARIZ. REV. STAT. § 36-2238 (“An ambulance service which is authorized to operate under any certificate of necessity issued pursuant to this article shall not abandon or discontinue any service to any portion of the service area established under the certificate without an order from the department, unless the certificate has expired, becomes invalid or is suspended or revoked.”).

<sup>171</sup> ARIZ. REV. STAT. § 36-2232(E).

<sup>172</sup> See ARIZ. REV. STAT. § 36-2239; Arizona Ground Ambulance Service Rate Schedule (2019) *infra* Appendix pp. 107–109.

<sup>173</sup> ARK. CODE § 20-13 *et seq.* (titled “Emergency Medical Services”). Please note that all citations to ARK. CODE § 20-13 *et seq.* herein are current with amendments received through Feb. 15, 2021 (Westlaw Edge).

<sup>174</sup> ARK. CODE § 20-13-209 (“The Department of Health shall have the authority and responsibility to: . . . “[e]nforce the rules and standards promulgated by [the Board] for the administration and enforcement of [ARK. CODE § 20-13-2 *et seq.*, titled “Emergency Medical Services Act”].”).

responsible for recommending rules on all matters relating to EMS to the Board.<sup>175</sup> The Council is comprised of various medical professionals who are appointed by the governor.<sup>176</sup> Interestingly, one of these members must be a licensed attorney with “knowledge of medical and legal issues.”<sup>177</sup> State law also provides that “[a]ll rules and standards relating to [EMS] promulgated and adopted by the [Council] and the [Board] . . . shall be submitted to [specified legislative committees] or appropriate subcommittees thereof for consideration before being placed in effect by the department or agency.”<sup>178</sup>

Arkansas law specifies that the state’s EMS laws apply to “[a]ll municipal, county, or state-operated rescue services which choose to provide advanced life support skills to the general public” regardless of whether the provider furnishes ALS transport or ALS non-transport service.<sup>179</sup> However, “any municipal, county, or state-operated or state-sponsored rescue service which

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<sup>175</sup> ARK. CODE § 20-13-207(a) (“The Emergency Medical Services Advisory Council shall recommend for adoption by the State Board of Health rules on all matters relating to emergency medical services . . .”).

<sup>176</sup> ARK. CODE § 20-13-205(a) (“There is created the Emergency Medical Services Advisory Council, which shall consist of nineteen [] members with a demonstrated interest in emergency medical services, to be appointed by the Governor as follows: (1) Four [] members shall be licensed medical doctors of good professional standing. One [] member shall be appointed representing each of the following areas: (A) The Arkansas Chapter of the American College of Emergency Physicians; (B) The Arkansas Academy of Family Physicians; (C) The Arkansas Medical Society, Inc.; and (D) The medical director for a licensed paramedic ambulance service; (2) One [] member recommended by the Arkansas Hospital Association, Inc.; (3) One [] member who shall be a member of the Arkansas Emergency Department Nurses Association; (4) One [] member who shall be a member of, and recommended by, The Arkansas Ambulance Association; (5) One [] member who shall be a licensed paramedic; (6) One [] member who shall be a licensed EMT; (7) One [] member representing fire department-based ambulance services; (8) One [] member representing emergency medical services personnel training sites who has had at least five [] years’ experience associated with emergency medical services personnel in this state; (9) One [] member who shall be a consumer representative who has an interest in public health and emergency medical services. The member shall be appointed by the Governor from the state at large; (10) One [] member who shall be sixty-five [] years of age or more. This member shall be appointed by the Governor from the state at large and shall not belong to any other group specifically addressed in this section, with the exception of the consumer representative; (11) One (1) member who shall represent city-based or county-based ambulance services; (12) One [] member who shall represent the Arkansas Association of Chiefs of Police or the Arkansas Sheriffs’ Association; (13) One [] member representing fire service rescue operations which do not transport patients; (14) One [] member licensed as an attorney at law in good professional standing within this state and having a knowledge of medical and legal issues; (15) One [] member appointed from a list of two [] nominees submitted by the Arkansas Emergency Medical Technicians Association; and (16) One [] member who shall be a certified military emergency medical technician.”).

<sup>177</sup> *Id.*

<sup>178</sup> ARK. CODE § 20-13-210(a)(1).

<sup>179</sup> ARK. CODE § 20-13-203(a).

provides basic life support skills to the public in a “treat, no transport” fashion” are explicitly exempt from the application of certain rules and standards.<sup>180</sup> An ambulance service’s service area must be in writing and on file with the Department.<sup>181</sup> Ambulance services are prohibited from advertising “the service areas, skills, procedures, or personnel certification levels which it cannot provide on every emergency request, twenty-four (24) hours a day, seven (7) days a week.”<sup>182</sup> Furthermore, the Department must revoke an ambulance service’s license if the ambulance service receives three “formal citations” during its license term for failing to comply with state law or any Department rule pertaining to EMS.<sup>183</sup>

Arkansas law also provides a legal mechanism through which a “quorum court” may establish a system to provide EMS to its residents.<sup>184</sup> In Arkansas, a quorum court is the legislative body of a county government, and is comprised of nine, eleven, thirteen, or fifteen members, depending on the population of the county.<sup>185</sup>

The quorum court of any county on its own motion or upon petition of ten percent (10%) of the electors of the county or any designated area of the county may establish by ordinance a system to provide emergency medical services to the residents of the county or the designated area.<sup>186</sup>

When a quorum court proposes to establish a system to provide EMS, it must “set a date for a public hearing on the question and shall cause notice of the time and place of the hearing to be published in a newspaper of general circulation in the county or in the area proposed to be

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<sup>180</sup> ARK. CODE § 20-13-203(b).

<sup>181</sup> ARK. CODE § 20-13-1004(b).

<sup>182</sup> ARK. CODE § 20-13-1004(a).

<sup>183</sup> ARK. CODE § 20-13-1005.

<sup>184</sup> See ARK. CODE § 20-13-301 (“It is the intent of this subchapter to authorize the quorum court in any county to provide emergency medical services for residents of the county or any designated area of the county and to provide for levying service charges upon residents of the area to provide funds for the purchase of equipment, the maintenance and operation of equipment, and the payment for personal services necessary to provide the services.”).

<sup>185</sup> *Quorum Court*, BOONE CNTY., ARK., <https://www.boonecountyar.com/quorum-court> (last visited Apr. 25, 2021).

<sup>186</sup> ARK. CODE § 20-13-303(a).

served.”<sup>187</sup> Any interested party residing in the county or in the designated area must be given an opportunity to appear at the hearing and “heard either for or against the establishment of the system.”<sup>188</sup> In turn, “the quorum court may adopt an ordinance establishing the emergency medical services system for the county or the designated area of the county or may refuse to act further on the matter” at its next meeting.<sup>189</sup>

If the quorum court enacts such an ordinance establishing an EMS system, the ordinance:

[S]hall specifically describe the area to be included within the system, shall describe the services to be provided the residents of the area, and shall specifically state the estimated cost of the services and the proposed method of financing the services, and such other matters as the quorum court deems appropriate to publicly advise residents of the county or the designated area of the purposes and costs of the system established in the ordinance.<sup>190</sup>

If a quorum court establishes an EMS system, the ordinance is subject to a referendum pursuant to ARK. CONST. amend. VII.<sup>191</sup>

Arkansas law also provides detailed provisions regarding the financing of EMS to the residents of a county or designated area of a county under such an ordinance.<sup>192</sup>

The service charges may be assessed and collected on a per capita, per household, or per unit of service basis or a combination of any of these, as may be determined by the quorum court, and shall be collected in such manner as may be prescribed by ordinance of the quorum court.<sup>193</sup>

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<sup>187</sup> ARK. CODE § 20-13-303(b)(1).

<sup>188</sup> ARK. CODE § 20-13-303(b)(2).

<sup>189</sup> ARK. CODE § 20-13-303(b)(3).

<sup>190</sup> ARK. CODE § 20-13-303(c).

<sup>191</sup> ARK. CODE § 20-13-304(b) (“The ordinance shall be subject to the referendum which may be exercised in the manner prescribed in Arkansas Constitution, Amendment 7, and laws enacted pursuant to Arkansas Constitution, Amendment 7, and the ordinance shall not be effective until the expiration of the time prescribed by the Arkansas Constitution and laws for the filing of referendum petitions.”).

<sup>192</sup> See ARK. CODE § 20-13-305.

<sup>193</sup> ARK. CODE § 20-13-305(b)(1).

State law also dictates that “[a]ll funds derived from the levy of service charges to support the furnishing of emergency medical services in the county or designated area shall be used only for the purposes for which levied . . . .”<sup>194</sup>

The quorum court of any county that has established a system of EMS for the residents of the county or designated areas of the county may discontinue furnishing such services “on its own motion or on petition of a majority of the qualified electors of the county or designated area.”<sup>195</sup> To do so, a public hearing must be held to provide “persons residing in the county or the designated area [] an opportunity to appear in behalf of or in opposition to the discontinuance of the services.”<sup>196</sup>

## 5. California

EMS in California is governed by CAL. HEALTH & SAFETY CODE § 1797 *et seq.* (titled “Emergency Medical Services”).<sup>197</sup> California’s EMS laws are administered by the Emergency Medical Services Authority (“EMSA”) of the Health and Welfare Agency (“Health & Welfare Agency”).<sup>198</sup> The Commission on Emergency Medical Services (“Commission”), which is an entity within the Health & Welfare Agency, is responsible for reviewing and approving EMS regulations, standards, and guidelines.<sup>199</sup> The Commission is comprised of various emergency medical responders, hospital personnel, and physicians who are appointed by the governor and

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<sup>194</sup> ARK. CODE § 20-13-305(c).

<sup>195</sup> ARK. CODE § 20-13-307(a).

<sup>196</sup> ARK. CODE § 20-13-307(b).

<sup>197</sup> CAL. HEALTH & SAFETY CODE § 1797 *et seq.* (titled “Emergency Medical Services”). Please note that all citations to CAL. HEALTH & SAFETY CODE § 1797 *et seq.* herein are current with urgency legislation through Ch. 13 of 2021 Regular Session (Westlaw Edge).

<sup>198</sup> CAL. HEALTH & SAFETY CODE § 1797.1 (“The Legislature finds and declares that it is the intent of this act to provide the state with a statewide system for emergency medical services by establishing within the Health and Welfare Agency the Emergency Medical Services Authority, which is responsible for the coordination and integration of all state activities concerning emergency medical services.”); CAL. HEALTH & SAFETY CODE § 1797.100 (“There is in the state government in the [CHWA], the [EMSA].”).

<sup>199</sup> CAL. HEALTH & SAFETY CODE § 1799.50; *see also* CAL. HEALTH & SAFETY CODE § 1797.107 (“The [EMSA] shall adopt, amend, or repeal after approval by the commission . . . such rules and regulations as may be reasonable and proper to carry out the purposes and intent of this division.”).

speaker of the assembly.<sup>200</sup> Additionally, the Interdepartmental Committee on Emergency Medical Services (“Committee”) is responsible for advising the EMSA “on the coordination and integration of all state activities concerning emergency medical services.”<sup>201</sup> The Committee is comprised of representatives from several state agencies and departments.<sup>202</sup>

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<sup>200</sup> CAL. HEALTH & SAFETY CODE § 1799.2 (“The commission shall consist of 19 members appointed as follows: (a) One full-time physician and surgeon, whose primary practice is emergency medicine, appointed by the Senate Committee on Rules from a list of three names submitted by the California Chapter of the American College of Emergency Physicians. (b) One physician and surgeon, who is a trauma surgeon, appointed by the Speaker of the Assembly from a list of three names submitted by the California Chapter of the American College of Surgeons. (c) One physician and surgeon appointed by the Senate Committee on Rules from a list of three names submitted by the California Medical Association. (d) One county health officer appointed by the Governor from a list of three names submitted by the California Conference of Local Health Officers. (e) One registered nurse, who is currently, or has been previously, authorized as a mobile intensive care nurse and who is knowledgeable in state emergency medical services programs and issues, appointed by the Governor from a pool of candidates submitted by the California Labor Federation and a pool of candidates submitted by the Emergency Nurses Association. (f) One full-time paramedic or EMT-II, who is not employed as a full-time peace officer, appointed by the Senate Committee on Rules from a pool of candidates submitted by the California Labor Federation and a pool of candidates submitted by the California Rescue and Paramedic Association. (g) One prehospital emergency medical service provider from the private sector, appointed by the Speaker of the Assembly from a list of three names submitted by the California Ambulance Association. (h) One management member of an entity providing fire protection and prevention services appointed by the Governor from a list of three names submitted by the California Fire Chiefs Association. (i) One physician and surgeon who is board prepared or board certified in the specialty of emergency medicine by the American Board of Emergency Medicine and who is knowledgeable in state emergency medical services programs and issues appointed by the Speaker of the Assembly. (j) One hospital administrator of a base hospital who is appointed by the Governor from a list of three names submitted by the California Hospital Association. (k) One full-time peace officer, who is either an EMT-II or a paramedic, who is appointed by the Governor from a list of three names submitted by the California Peace Officers Association. (l) Two public members who have experience in local EMS policy issues, at least one of whom resides in a rural area as defined by the authority, and who are appointed by the Governor. (m) One administrator from a local EMS agency appointed by the Governor from a list of four names submitted by the Emergency Medical Services Administrator’s Association of California. (n) One medical director of a local EMS agency who is an active member of the Emergency Medical Directors Association of California and who is appointed by the Governor. (o) One person appointed by the Governor, who is an active member of the California State Firemen’s Association. (p) One person who is employed by the Department of Forestry and Fire Protection (CAL-FIRE) appointed by the Governor from a list of three names submitted by the California Professional Firefighters. (q) One person who is employed by a city, county, or special district that provides fire protection appointed by the Governor from a list of three names submitted by the California Professional Firefighters. (r) One medical director of a public fire protection agency in the state appointed by the Governor from a list of three names submitted by the California Professional Firefighters.”).

<sup>201</sup> CAL. HEALTH & SAFETY CODE § 1797.132.

<sup>202</sup> *Id.* (“The committee shall include a representative from each of the following state agencies and departments: the Office of Emergency Services, the Department of the California Highway Patrol, the Department of Motor Vehicles, a representative of the administrator of the California Traffic Safety Program . . . the Medical Board of California, the State Department of Public Health, the Board of Registered Nursing, the State Department of Education, the National Guard, the Office of Statewide Health Planning and Development, the State Fire Marshal, the California Conference of Local Health Officers, the Department of Forestry and Fire Protection, the Chancellor's Office of the California Community Colleges, and the Department of General Services.”).

California law provides that the EMSA “shall assess each EMS area or the system’s service area for the purpose of determining the need for additional emergency medical services, coordination of emergency medical services, and the effectiveness of emergency medical services.”<sup>203</sup> In turn, the EMSA must “develop planning and implementation guidelines for emergency medical services systems” addressing personnel and training, communications, transportation, assessment of hospital and critical care centers, system organization and management, data collection and evaluation, public information and education, and disaster response.<sup>204</sup> The EMSA must also “receive plans for the implementation of emergency medical services and trauma care systems from local EMS agencies.”<sup>205</sup>

The local EMS agency (“LEMSA”) in each designated EMS area must implement and submit an annual plan to the EMSA outlining how EMS will be furnished within the area.<sup>206</sup> The EMSA may reject such a plan if it “does not effectively meet the needs of the persons served and is not consistent with coordinating activities in the geographical area served, or that the plan is not concordant and consistent with applicable guidelines or regulations, or both the guidelines and regulations, established by the authority.”<sup>207</sup> The LEMSAs may subsequently appeal a determination that their plan is deficient to the Commission.<sup>208</sup>

The LEMSAs “may create one or more exclusive operating areas in the development of a local plan, if a competitive process is utilized to select the provider or providers of the services pursuant to the plan.”<sup>209</sup> However, “[n]o competitive process is required if the local EMS agency develops or implements a local plan that continues the use of existing providers operating within

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<sup>203</sup> CAL. HEALTH & SAFETY CODE § 1797.102.

<sup>204</sup> CAL. HEALTH & SAFETY CODE § 1797.103.

<sup>205</sup> CAL. HEALTH & SAFETY CODE § 1797.105(a).

<sup>206</sup> CAL. HEALTH & SAFETY CODE § 1797.254.

<sup>207</sup> CAL. HEALTH & SAFETY CODE § 1797.105(b).

<sup>208</sup> CAL. HEALTH & SAFETY CODE § 1797.105(c).

<sup>209</sup> CAL. HEALTH & SAFETY CODE § 1797.224.

a local EMS area in the manner and scope in which the services have been provided without interruption since January 1, 1981.”<sup>210</sup> If a LEMSA chooses to create one or more exclusive operating areas, it must submit the competitive process utilizes for selecting the providers and the scope of their operations to the EMSA for approval as part of the local EMS plan.<sup>211</sup> Additionally, the competitive process must be conducted at periodic intervals, although the statute does not specify a minimum or maximum requirement for such intervals.<sup>212</sup>

Notably, state law stipulates that any regulations, standards, and guidelines adopted by the EMSA or a LEMSA “shall not prohibit hospitals which contract with group practice prepayment health care service plans from providing necessary medical services for the members of those plans.”<sup>213</sup>

## **6. Colorado**

EMS in Colorado is governed by COLO. REV. STAT. § 25-3.5 *et seq.* (titled “Emergency Medical and Trauma Services”).<sup>214</sup> Colorado’s EMS laws are administered and enforced by the Colorado Board of Health (“Board”) through the Department of Public Health and Environment (“Department”). The Emergency Medical and Trauma Services Advisory Council (“Council”), which is an entity within the Department, is responsible for several things, including advising the Department on EMS matters and reviewing and approving rules promulgated by the Board

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<sup>210</sup> *Id.*

<sup>211</sup> *Id.*

<sup>212</sup> *Id.*

<sup>213</sup> CAL. HEALTH & SAFETY CODE § 1797.106(a).

<sup>214</sup> COLO. REV. STAT. § 25-3.5 *et seq.* (titled “Emergency Medical and Trauma Services”). Please note that all citations to COLO. REV. STAT. § 25-3.5 *et seq.* herein are current through legislation effective Apr. 7, 2021 of the First Regular Session of the 73rd General Assembly (2021) (Westlaw Edge).



pertaining to EMS.<sup>215</sup> The Council is comprised of various administrative officials, emergency medical responders, hospital personnel, and physicians.<sup>216</sup>

Colorado law provides that “no person shall provide ambulance service publicly or privately in this state unless that person holds a valid license to do so issued by the board of county commissioners of the county in which the ambulance service is based . . . .”<sup>217</sup> The board of county commissioners must issue an ambulance service license if certain criteria are satisfied.

The board of county commissioners shall issue a license to the applicant to provide ambulance service and a permit for each ambulance used . . . upon a finding that the applicant’s staff, vehicle, and equipment comply with the provisions of this part 3 and any other requirement established by said board.<sup>218</sup>

The board of county commissioners may also temporarily suspend an ambulance service license for a maximum of thirty days “[u]pon a determination . . . that any person has violated or failed to comply with any provision of [state law governing air or ground ambulances].”<sup>219</sup> The licensee must be given written notice of the temporary suspension and a hearing within ten days of the temporary suspension.<sup>220</sup> The board of county commissioners may suspend the license “for any portion of or for the remainder of its life.”<sup>221</sup> The ambulance service may subsequently apply for a new license, subject to the original application procedure.<sup>222</sup> However, the board of county commissioners may permanently revoke a license “[u]pon a second violation or failure to comply with any provision of [state law governing air or ground ambulances].”<sup>223</sup>

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<sup>215</sup> COLO. REV. STAT. § 25-3.5-104(1)(a); COLO. REV. STAT. § 25-3.5-104(4)(a)–(d).

<sup>216</sup> COLO. REV. STAT. § 25-3.5-104(1)(b) (listing the Council’s various members); *see also* COLO. REV. STAT. § 25-3.5-104(1)(c) (providing that the council shall consist of several additional ex officio, nonvoting members).

<sup>217</sup> COLO. REV. STAT. § 25-3.5-301(1).

<sup>218</sup> COLO. REV. STAT. § 25-3.5-302(1)(b).

<sup>219</sup> COLO. REV. STAT. § 25-3.5-303(1).

<sup>220</sup> *Id.*

<sup>221</sup> *Id.*

<sup>222</sup> *Id.*

<sup>223</sup> COLO. REV. STAT. § 25-3.5-303(2).

## 7. Connecticut

EMS in Connecticut is governed by CONN. GEN. STAT. § 19a-175 *et seq.* (titled “Emergency Medical Services”).<sup>224</sup> Connecticut’s EMS laws are administered and enforced by the Office of Emergency Medical Services (“OEMS”) within the Department of Public Health (“Department”).<sup>225</sup> The regulations promulgated by the Department are compiled at CONN. AGENCIES REGS. § 19a-179 *et seq.* (titled “Office of Emergency Medical Services”) and CONN. AGENCIES REGS. § 19a-180 *et seq.* (titled “Need for Emergency Medical Services”).<sup>226</sup>

Like Minnesota, Connecticut law requires the Department to establish primary service areas for EMS providers and designate a primary service area responder (“PSAR”) for each PSA:

The commissioner shall: . . . [] Establish primary service areas and assign in writing a primary service area responder for each primary service area. Each state-owned campus having an acute care hospital on the premises shall be designated as the primary service area responder for that campus[.]<sup>227</sup>

Every town in Connecticut is part of a PSA for first responder and basic ambulance service, and most have paramedic-level service. Connecticut regulations require that every EMS service must be available to respond to emergency calls within its PSA twenty-four hours a day, seven days a week, or must arrange with another certified or licensed response service to cover its PSA during non-operational hours with no reduction in the level of service.<sup>228</sup>

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<sup>224</sup> CONN. GEN. STAT. § 19a-175 *et seq.* (titled “Emergency Medical Services”). Please note that all citations to CONN. GEN. STAT. § 19a-175 *et seq.* herein are current with all enactments of 2021 Regular Session enrolled and approved by the Governor on or before Mar. 31, 2021 and effective on or before Mar. 31, 2021 (Westlaw Edge).

<sup>225</sup> CONN. GEN. STAT. § 19a-176 (“The Department of Public Health shall be the lead agency for the state’s emergency medical services program and shall be responsible for the planning, coordination and administration of a state-wide emergency medical care service system . . .”).

<sup>226</sup> CONN. AGENCIES REGS. § 19a-179 *et seq.* (titled “Office of Emergency Medical Services”); CONN. AGENCIES REGS. § 19a-180 *et seq.* (titled “Need for Emergency Medical Services”). Please note that all citations to CONN. AGENCIES REGS. § 19a-179 *et seq.* and CONN. AGENCIES REGS. § 19a-180 *et seq.* herein are current with material published on the CT eRegulations System through Apr. 13, 2021 (Westlaw Edge).

<sup>227</sup> CONN. GEN. STAT. § 19a-177(10); *see also* CONN. AGENCIES REGS. § 19a-179-4(a) (“OEMS shall assign, in writing, a primary service area responder for each primary service area. All municipalities within the State of Connecticut shall be covered by said assignments . . .”). *Cf.* MINN. STAT. § 144E.06 (2020).

<sup>228</sup> CONN. AGENCIES REGS. § 19a-179-11.

Regulations dictate that the Department must consider several factors before assigning an EMS provider as a PSAR:

- (1) Size of population to be served;
- (2) Effect of proposed PSAR assignment on other emergency medical service providers in the area;
- (3) Geographic locations of the proposed PSAR provider;
- (4) The proposed PSAR's record of response time;
- (5) The proposed PSAR's record of activation time;
- (6) The proposed PSAR's level of licensure or certification; and,
- (7) Other factors which OEMS determines to be relevant to the provision of efficient and effective emergency medical services to the population to be served.<sup>229</sup>

Like Minnesota's EMSRB, the Department must also seek the advice and recommendations of the appropriate regional council and chief administrative official of the affected town.<sup>230</sup> Unlike Minnesota, Connecticut law dictates that the Department *must* "[r]evoke primary service area assignments upon determination by the commissioner that it is in the best interests of patient care to do so."<sup>231</sup> There are two administrative procedures through which a PSA assignment may be revoked.

The first procedure is initiated upon the recommendation of the regional EMS council:

A PSAR assignment may be withdrawn when it is determined by OEMS that it is in the best interests of patient care to do so. Upon transmittal to OEMS of the recommendation of the appropriate regional council, along with reasons in support of said recommendation, that withdrawal of a PSAR assignment is appropriate, OEMS shall institute proceedings pursuant to [CONN. GEN. STAT. §§ 19a-177 – 19a-182], inclusive, and the applicable regulations of the department of health services promulgated thereunder. The regional council and the designated primary service area responder shall be permitted to present evidence and arguments to the commissioner in support of their respective positions. Upon consideration of the council

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<sup>229</sup> CONN. AGENCIES REGS. § 19a-179-4(b).

<sup>230</sup> CONN. AGENCIES REGS. § 19a-179-4(b) ("Prior to such assignment, OEMS shall solicit the advice and recommendation of the appropriate regional council and the chief administrative official of the municipality in which the PSAR lies for consideration in light of the above factors."). Cf. MINN. STAT. § 144E.11(2) (2020).

<sup>231</sup> CONN. GEN. STAT. § 19a-177(11).

recommendation and any other evidence or argument presented, the commissioner shall make a decision, in writing, whether to withdraw the assignment. If an assignment is withdrawn, OEMS shall at the same time assign the PSAR responsibility to another provider. The commissioner may initiate such proceedings without being requested to do so by the council, but shall notify the council of its intent.<sup>232</sup>

The second procedure is initiated upon the petition of the chief administrative official of the municipality in which the PSA lies:

Where the chief administrative official of the municipality in which the PSA lies can demonstrate to the commissioner that an emergency exists and that the safety, health and welfare of the citizens of the affected area are jeopardized by the performance of the assigned primary service area responder, that chief administrative official may petition the commissioner, in writing, to suspend the assignment immediately. In such cases, the chief administrative official shall develop a plan acceptable to the commissioner for the alternative provision of primary service area responder responsibilities. Upon a finding that an emergency exists and that the safety, health, and welfare of the citizens of the affected area are jeopardized by the performance of the assigned primary service area responder, the commissioner may suspend the assignment immediately and order a plan for alternative provision of emergency medical services, pending prompt compliance with the requirements of the subsection (d) above.<sup>233</sup>

Connecticut law provides that any municipality may petition the Department for the removal of a PSAR “at any time if based on an allegation that a *performance crisis* exists and that the safety, health and welfare of the citizens of the affected primary service area are jeopardized by the responder’s performance” or “not more often than once every three years, if based on the *unsatisfactory performance* of the responder.”<sup>234</sup>

The law specifies that “performance crisis” means:

(A) the responder has failed to respond to at least fifty per cent or more first call responses in any rolling three-month period and

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<sup>232</sup> CONN. AGENCIES REGS. § 19a-179-4(d).

<sup>233</sup> CONN. AGENCIES REGS. § 19a-179-4(e).

<sup>234</sup> CONN. GEN. STAT. § 19a-181c(b) (emphasis added).

has failed to comply with the requirements of any corrective action plan agreement between the municipality and the responder, or

- (B) the sponsor hospital refuses to endorse or provide a recommendation for the responder due to unresolved issues relating to the quality of patient care provided by the responder.<sup>235</sup>

The law specifies that “unsatisfactory performance” means the responder has failed to:

- (A) respond to at least eighty per cent or more first call responses, excluding those responses excused by the municipality in any rolling twelve-month review period, or
- (B) meet defined response time standards agreed to between the municipality and responder, excluding those responses excused by the municipality, and comply with the requirements of a mutually agreed-upon corrective action plan, or
- (C) investigate and adequately respond to complaints related to the quality of emergency care or response times, on a repeated basis, or
- (D) report adverse events as required by the Commissioner of Public Health or as required under the local emergency medical services plan, on a repeated basis, or
- (E) communicate changes to the level of service or coverage patterns that materially affect the delivery of service as required under the local emergency medical services plan or communicate an intent to change such service that is inconsistent with such plan, or
- (F) communicate changes in its organizational structure that are likely to negatively affect the responder’s delivery of service, and
- (G) deliver services in accordance with the local emergency medical services plan.<sup>236</sup>

If a municipality seeks to change its PSAR, it must submit an alternative plan for furnishing

EMS within the PSA when:

- (1) The municipality’s current primary service area responder has failed to meet the standards outlined in the local emergency medical services plan, established pursuant to [CONN. GEN. STAT. § 19a-181b];
- (2) the municipality has established a performance crisis or unsatisfactory performance, as defined in [CONN. GEN. STAT. § 19a-181c];

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<sup>235</sup> CONN. GEN. STAT. § 19a-181c(a)(2).

<sup>236</sup> CONN. GEN. STAT. § 19a-181c(a)(3).

- (3) the primary service area responder does not meet a performance measure provided in regulations adopted pursuant to [CONN. GEN. STAT. § 19a-179];
- (4) the municipality has developed a plan for regionalizing service; or
- (5) the municipality has developed a plan that will improve or maintain patient care and the municipality has the opportunity to align a new primary service area responder that is better suited than the current primary service area responder to meet the community's current needs. Such plan shall include the name of a recommended primary service area responder for each category of emergency medical response services.<sup>237</sup>

There is also a process through which municipalities may petition the Department to hold a hearing if it cannot reach an agreement with its PSAR regarding performance standards.<sup>238</sup>

## 8. Delaware

EMS in Delaware is governed by 16 DEL. CODE §§ 9700 *et seq.* (titled “Emergency Medical Services”)<sup>239</sup> and 9800 *et seq.* (titled “Paramedic Services”).<sup>240</sup> Delaware’s EMS laws are administered and enforced by the Office of Emergency Medical Services (“OEMS”) within the Department of Health and Social Services (“Department”). The Emergency Medical Services Oversight Council (“Council”) is responsible for several things, including evaluating the state’s EMS system, formulating objective criteria for evaluating EMS provider performance, and making legislative recommendations.<sup>241</sup> The Council is comprised of various state government officials and medical professionals, some of whom are appointed by the governor and others by their respective professional associations.<sup>242</sup>

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<sup>237</sup> CONN. GEN. STAT. § 19a-181f(a).

<sup>238</sup> See CONN. GEN. STAT. § 19a-181d.

<sup>239</sup> 16 DEL. CODE § 9700 *et seq.* (titled “Emergency Medical Services”). Please note that all citations to 16 DEL. CODE § 9700 *et seq.* herein are current through Ch. 11 of the 151st General Assembly (2021-2022) (Westlaw Edge).

<sup>240</sup> 16 DEL. CODE § 9800 *et seq.* (titled “Paramedic Services”). Please note that all citations to 16 DEL. CODE § 9800 *et seq.* herein are current through Ch. 11 of the 151st General Assembly (2021-2022) (Westlaw Edge).

<sup>241</sup> 16 DEL. CODE § 9703(f) (listing the duties and responsibilities of the Council).

<sup>242</sup> 16 DEL. CODE § 9703(a) (“The Council shall consist of the following members: (1) A representative of the Office of the Governor appointed by the Governor; (2) The Secretary of the Department of Safety and Homeland Security;

The Delaware State Fire Prevention Commission (“Commission”) is tasked with inspecting and certifying all ambulance service providers in the state.<sup>243</sup> The Commission also has the authority to establish ambulance service districts<sup>244</sup> and assign primary and secondary BLS ambulance service providers within each ambulance service district.<sup>245</sup> The Commission is authorized to select a new primary BLS ambulance service provider if:

- 6.2.1 The current Primary BLS Ambulance Service Provider chooses to discontinue service; or
- 6.2.2 The Commission determines that there has been failure to meet one or more elements of this Regulation, which creates a threat to public safety; or
- 6.2.3 The current Primary BLS Ambulance Service Provider either directly or indirectly, by merger or affiliation or through contractual agreement transfers or assigns Primary BLS Ambulance Service to any person, firm, corporation, other business or non-profit entity not authorized by the Commission to provide BLS Ambulance Service within the Primary BLS Ambulance Service Provider's Ambulance Service District.<sup>246</sup>

Any BLS ambulance service provider that intends to terminate furnishing BLS ambulance services must notify the Commission and follow several administrative steps.<sup>247</sup>

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(3) The Secretary of the Department of Health and Social Services, or at the discretion of the Secretary, the Director of Public Health; (4) The Chair of the Delaware State Fire Prevention Commission or another Commissioner selected by the Chair; (5) The President of the Delaware Volunteer Firefighter’s Association; (6) The Chief of the New Castle County Emergency Medical Services or, at the Chief’s discretion, a representative from the New Castle County Emergency Medical Services; (7) The Kent County Administrator or, at the Administrator’s discretion, the Kent County EMS Chief; (8) The Sussex County Administrator, or at the Administrator’s discretion, the Sussex County EMS Director; (9) The President of the Delaware Chapter of the American College of Emergency Physicians; (10) The State EMS Medical Director; (11) The Chair of the Trauma Systems Committee; (12) A practicing paramedic, certified and employed in the State, appointed by the Governor; (13) The Chair of the DVFA Ambulance Advisory Committee; (14) Three additional at-large members, 1 from each county, appointed by the Governor; (15) The President of the Delaware Healthcare Association or, at the President's discretion, a representative of the Delaware Healthcare Association. (16) The Executive Director of the Medical Society of Delaware or, at the Executive Director’s discretion, a representative of the Medical Society of Delaware; (17) The Chair of the Delaware Police Chiefs' Council or, at the Chair's discretion, a representative of the Delaware Police Chief’s Council; (18) The Paramedic Commander of the Delaware State Police Aviation Unit; (19) The Chair of the Emergency Medical Services for Children (EMSC) Advisory Committee, or at the discretion of the EMSC Advisory Committee Chair, the EMSC Program Manager; and (20) The Chair of the Stroke System Committee.”).

<sup>243</sup> See 16 DEL. CODE § 9705(d).

<sup>244</sup> 16 DEL. CODE § 6717(a); 1 DEL. ADMIN. CODE. § 710-5.0

<sup>245</sup> 1 DEL. ADMIN. CODE. § 710-6.1.

<sup>246</sup> 1 DEL. ADMIN. CODE. § 710-6.2.

<sup>247</sup> 1 DEL. ADMIN. CODE. § 710-13.0.

## 9. Florida

EMS in Florida is governed by FLA. STAT. § 401 *et seq.* (titled “Medical Telecommunications and Transportation”).<sup>248</sup> Florida’s EMS laws are administered and enforced by the Department of Health (“Department”). The Emergency Medical Services Advisory Council (“Council”) is responsible for several things, including “[i]dentifying and making recommendations to the department concerning the appropriateness of suggested changes to statutes and administrative rules.”<sup>249</sup>

Florida law provides that the Department must issue an ambulance services license if, among other things, “[t]he applicant has obtained a certificate of public convenience and necessity from each county in which the applicant will operate. In issuing the certificate of public convenience and necessity, the governing body of each county shall consider the recommendations of municipalities within its jurisdiction.”<sup>250</sup> Such licenses are valid for two years from the date of issuance.<sup>251</sup> The Department may suspend or revoke such license “at any time if it determines that the licensee has failed to maintain compliance with the requirements prescribed for operating a basic or advanced life support service.”<sup>252</sup>

Counties “may adopt ordinances that provide reasonable standards for certificates of public convenience and necessity for basic or advanced life support services and air ambulance services.”<sup>253</sup> If the governing body of a county chooses to develop such standards for certificates of public convenience and necessity, it “must consider state guidelines, recommendations of the

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<sup>248</sup> FLA. STAT. § 401 *et seq.* (titled “Medical Telecommunications and Transportation”). Please note that all citations to FLA. STAT. § 401 *et seq.* herein are current through Ch. 1 of the 2021 First Regular Session of the Twenty-Seventh Legislature (Westlaw Edge).

<sup>249</sup> FLA. STAT. § 401.245(1)(a)–(l).

<sup>250</sup> FLA. STAT. § 401.25(2)(d).

<sup>251</sup> FLA. STAT. § 401.25(4).

<sup>252</sup> FLA. STAT. § 401.25(3).

<sup>253</sup> FLA. STAT. § 401.25(6).



local or regional trauma agency created under [FLA. STAT. § 395], and the recommendations of municipalities within its jurisdiction.”<sup>254</sup> Florida’s EMS statutes and regulations *do not* indicate that a certificate of necessity grants EMS providers *exclusive* operations within their service area.

## 10. Georgia

EMS in Georgia is governed by GA. STAT. § 31-11 *et seq.* (titled “Emergency Medical Services”).<sup>255</sup> Georgia’s EMS laws are administered and enforced by the Board of Public Health (“Board”) through the Office of Emergency Medical Services and Trauma (“OEMST”) within the Department of Public Health (“Department”).<sup>256</sup> The Emergency Medical Services Advisory Council (“Council”) is responsible for “advis[ing] [the Dep’t of Pub. Health] in matters essential to its operations with respect to emergency medical services systems.”<sup>257</sup> The Council is comprised of various medical professionals who are appointed by the commissioner of the Department.<sup>258</sup>

Georgia law provides that ambulance service licenses are issued by the Department.<sup>259</sup> An application for an ambulance service license must include “[t]he location and description of the place or places from which the ambulance service is intended to operate” but contains no geographic restrictions.<sup>260</sup> The Department may suspend or revoke an ambulance service license

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<sup>254</sup> *Id.*

<sup>255</sup> GA. STAT. § 31-11 *et seq.* (titled “Emergency Medical Services”). Please note that all citations to GA. STAT. § 31-11 *et seq.* herein are current through Laws 2021, Act 10 (Westlaw Edge).

<sup>256</sup> See GA. STAT. § 31-11-31 (establishing a licensing procedure for prospective ambulance service licensees).

<sup>257</sup> GA. COMP. R. & REGS. 511-9.03(1)(a); *see also* GA. COMP. R. & REGS. 511-9.03(2)(a) (establishing a statewide Emergency Medical Services Medical Directors Advisory Council to advise GDPH “on issues related to medical direction of the EMS system.”).

<sup>258</sup> GA. COMP. R. & REGS. 511-9.03(1)(b)(4) (“Membership shall include representation from each of the following categories, provided that a single member may represent more than one category: (i) At least one representative from each of the state’s ten EMS Regions; (ii) At least one representative from each of the following systems of care: (a) Cardiac (b) Stroke (c) Trauma (d) Pediatrics (e) Perinatal Care/Obstetrics (iii) A representative from the statewide Emergency Medical Services Medical Director’s Advisory Council; (iv) A representative of EMS education; (v) A representative from a fire/rescue service; (vi) A representative from an emergency management agency; (vii) At least one representative from each of the following EMS agency license types: (a) Ground Ambulance (b) Neonatal Ambulance (c) Air Ambulance (d) Medical First Responder (viii) At least one representative from each of the following EMS agency ownership types: (a) Government (City, County or State) (b) Private (Corporation, Limited Liability Company, Sole Proprietorship, or other entity) (c) Hospital (ix) Consumers or experts in the field of EMS.”).

<sup>259</sup> See GA. STAT. § 31-11-31 (establishing a licensing procedure for prospective ambulance service licensees).

<sup>260</sup> GA. STAT. § 31-11-31(5).

“for a failure of a licensee to comply and to maintain compliance with [state EMS laws and regulations], but only after opportunity for a hearing . . . .”<sup>261</sup>

## 11. Hawaii

EMS in Hawaii is governed by HAW. REV. STAT. § 321-221 *et seq.* (titled “State Comprehensive Emergency Medical Services System”).<sup>262</sup> Hawaii’s EMS laws are administered and enforced by the Department of Health (“Department”). The Emergency Medical Services Advisory Committee (“Committee”), which is an entity within the Department, is responsible for advising the Department “on all matters relating to the state [EMS] system.”<sup>263</sup> The Committee is comprised of several civilians, medical professionals, and government officials.<sup>264</sup>

Hawaii law provides that the Department must consult with the Committee and determine the levels of EMS that are to be implemented in each county.<sup>265</sup>

The department may contract to provide emergency medical services, including emergency aeromedical services, or any necessary component of a county emergency services system in conformance with the state system. In the event any county shall apply to the department to operate emergency medical ambulance services within the respective county, the department may contract with the county for the provision of those services. The department shall operate emergency medical ambulance services or contract

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<sup>261</sup> GA. STAT. § 31-11-36(a).

<sup>262</sup> HAW. REV. STAT. § 321-221 *et seq.* (titled “State Comprehensive Emergency Medical Services System”). Please note that all citations to HAW. REV. STAT. § 321-221 *et seq.* herein are current through Act 1 of the 2021 Regular Session (Westlaw Edge).

<sup>263</sup> HAW. REV. STAT. § 321-225(a)

<sup>264</sup> HAW. REV. STAT. § 321-225(b) (“The advisory committee shall be composed of twenty members: three nonvoting ex-officio members, who shall be the director of transportation, the adjutant general, and the administrator of the state health planning and development agency, or the designated representatives thereof, and seventeen members representing all counties of the State who shall be appointed by the governor subject to section 26-34 as follows: (1) Five members who shall be physicians experienced in the conduct and delivery of emergency medical services; provided that at least two shall be engaged in the practice of emergency medicine and be board-eligible or board-certified by the American Board of Emergency Medicine, and provided further that at least one physician shall be engaged in the practice of pediatrics and be board-eligible or board-certified by the American Board of Pediatrics; (2) Four members who shall be consumers of health care and who shall have no connection with or relationship to the health care system of the State and who shall be representative of all counties; (3) Four members of allied health professions related to emergency medical services; and (4) Four members, one from each county, who shall be mobile intensive care technicians or emergency medical technicians engaged in the practice of pre-hospital emergency medical service.”).

<sup>265</sup> HAW. REV. STAT. § 321-228.

with a private agency in those counties which do not apply to it under this section. Any county or private agency contracting to provide emergency medical ambulance services under this section shall be required by the department to implement those services in a manner and at a level consistent with the levels determined under this section.<sup>266</sup>

## 12. Idaho

EMS in Idaho is governed by IDAHO CODE § 56-10 *et seq.* (titled “Department of Health and Welfare”).<sup>267</sup> Idaho’s EMS laws are administered and enforced by the Bureau of Emergency Medical Services and Preparedness (“Bureau”) within the Department of Health and Welfare (“Department”). The Emergency Medical Services Physician Commission (“Commission”), which is an entity within the Department, is responsible for “establishing standards for scope of practice and medical supervision for licensed personnel and agencies.”<sup>268</sup> The Commission is comprised of various medical professionals and others appointed by the governor.<sup>269</sup>

Idaho law provides that “[e]ach ambulance service, air medical service and nontransport service shall be licensed by the EMS bureau based on the level of licensed personnel it utilizes, transport capability *and self-declared geographic coverage area* and shall meet [certain statutory requirements].”<sup>270</sup> The Bureau must provide notice of ambulance service license applications to

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<sup>266</sup> *Id.*

<sup>267</sup> IDAHO CODE § 56-10 *et seq.* (titled “Department of Health and Welfare”). Please note that all citations to IDAHO CODE § 56-10 *et seq.* herein are current through Ch. 144 of the First Reg. Sess. of the 66th Idaho Legislature (Westlaw Edge).

<sup>268</sup> IDAHO CODE § 56-1013A(1).

<sup>269</sup> IDAHO CODE § 56-1013A(2) (“The commission shall be composed of eleven [] voting members appointed by the governor upon assurance of equitable geographic and rural representation. Six [] members shall be physicians currently licensed in Idaho and appointed as follows: one [] member representing the Idaho board of medicine as provided in [IDAHO CODE § 54-18], one [] member representing the Idaho medical association, one [] member representing the EMS bureau, one [] member representing the Idaho chapter of the American college of emergency physicians, one [] member representing the Idaho chapter of the American academy of pediatrics and one [] member representing the Idaho chapter of the American college of surgeons committee on trauma. Three [] members shall be physicians currently licensed in Idaho and practicing as an EMS medical director representing the following associations: one [] member representing the Idaho association of counties, one [] member representing the Idaho fire chiefs association and one (1) member representing the Idaho hospital association. Two [] members shall be Idaho citizens representing the public interest.”).

<sup>270</sup> IDAHO CODE § 56-1016.

“all cities, counties and other units of local government that have any geographic coverage area in common with the applicant.”<sup>271</sup> In order to receive a license, an ambulance service must agree to provide “[a] declaration of anticipated applicant agency costs and revenues; a statement of projected changes in response time; and a narrative describing projected clinical benefits to patients resulting from licensure using methods defined in board rules”<sup>272</sup> and “[c]ollect and report data to the EMS bureau upon receiving a license using a data collection system.”<sup>273</sup>

### **13. Illinois**

EMS in Illinois is governed by 210 ILL. COMP. STAT. 50 *et seq.* (titled “Emergency Medical Services (EMS) Systems Act”).<sup>274</sup> Illinois’ EMS laws area administered and enforced by the Department of Public Health (“Department”).<sup>275</sup> Illinois law provides that the Department must designate EMS Regions within the state, “consisting of specific geographic areas encompassing EMS Systems and trauma centers, in which emergency medical services, trauma services, and non-emergency medical services are coordinated under an EMS Region Plan.”<sup>276</sup> The Department retains the authority to “[a]pprove BLS, ILS and ALS level EMS Systems”, which are “organization[s] of hospitals, vehicle service providers and personnel approved by the Department in a specific geographic area.”<sup>277</sup>

### **14. Indiana**

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<sup>271</sup> IDAHO CODE § 56-1016(8).

<sup>272</sup> IDAHO CODE § 56-1016(7)(a).

<sup>273</sup> IDAHO CODE § 56-1016(7)(b).

<sup>274</sup> 210 ILL. COMP. STAT. 50 *et seq.* (titled “Emergency Medical Services (EMS) Systems Act”). Please note that all citations to 210 ILL. COMP. STAT. 50 *et seq.* herein are current through P.A. 101-673 of the 2020 Reg. Sess. and P.A. 102-3 of the 2021 Reg. Sess. (Westlaw Edge).

<sup>275</sup> See 210 ILL. COMP. STAT. 50/3.15.

<sup>276</sup> 210 ILL. COMP. STAT. 50/3.15.

<sup>277</sup> *Id.*

EMS in Indiana is governed by IND. CODE § 16-31 *et seq.* (titled “Emergency Medical Services”).<sup>278</sup> Indiana’s EMS laws are administered and enforced by the Emergency Medical Services Commission (“Commission”) within the Department of Homeland Security (“Department”).<sup>279</sup> The Commission is comprised of various medical professionals who are appointed by the governor.<sup>280</sup>

Indiana law provides that the governing body of “a city, town, township, or county” may:

- (1) Establish, operate, and maintain emergency medical services.
- (2) Levy taxes under and . . . expend appropriated funds of the political subdivision to pay the costs and expenses of establishing, operating, maintaining, or contracting for emergency medical services.
- (3) [A]uthorize, franchise, or contract for emergency medical services. However:
  - (A) a county may not provide, authorize, or contract for emergency medical services within the limits of any city without the consent of the city; and
  - (B) a city or town may not provide, authorize, franchise, or contract for emergency medical services outside the limits of the city or town without the approval of the governing body of the area to be served.
- (4) Apply for, receive, and accept gifts, bequests, grants-in-aid, state, federal, and local aid, and other forms of financial assistance for the support of emergency medical services.

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<sup>278</sup> IND. CODE § 16-31 *et seq.* (titled “Emergency Medical Services”). Please note that all citations to IND. CODE § 16-31 *et seq.* herein are current through legislation of the 2021 First Reg. Sess. of the 122nd General Assembly effective through Apr. 20, 2021 (Westlaw Edge).

<sup>279</sup> See IND. CODE § 16-31-2-1 (“The Indiana emergency medical services commission is created.”).

<sup>280</sup> IND. CODE § 16-31-2-2(a) (“The governor shall appoint the members for four [] year terms as follows: (1) One [] must be appointed from a volunteer fire department that provides emergency medical service. (2) One [] must be appointed from a full-time municipal fire or police department that provides emergency medical service. (3) One [] must be a nonprofit provider of emergency ambulance services organized on a volunteer basis other than a volunteer fire department. (4) One [] must be a provider of private ambulance services. (5) One [] must be a state licensed paramedic. (6) One [] must be a licensed physician who: (A) has a primary interest, training, and experience in emergency medical services; and (B) is currently practicing in an emergency medical services facility. (7) One [] must be a chief executive officer of a hospital that provides emergency ambulance services. (8) One [] must be a registered nurse who has supervisory or administrative responsibility in a hospital emergency department. (9) One [] must be a licensed physician who: (A) has a primary interest, training, and experience in trauma care; and (B) is practicing in a trauma facility. (10) One [] must be a state certified emergency medical service technician. (11) One [] must be an individual who: (A) represents the public at large; and (B) is not in any way related to providing emergency medical services. (12) One [] must be a program director (as defined in 836 IAC 4-2-2(12)(B)(iii)) for a commission certified advanced life support training institution. (13) One [] must be the deputy executive director appointed under IC 10-19-5-3 to manage the division of preparedness and training of the department of homeland security or the designee of the deputy executive director. (14) One [] must be a representative of an entity that provides air ambulance services.”).

- (5) Establish and provide for the collection of reasonable fees for emergency ambulance services the governing body provides under this chapter.
- (6) Pay the fees or dues for individual or group membership in any regularly organized volunteer emergency medical services association on their own behalf or on behalf of the emergency medical services personnel serving that unit of government.<sup>281</sup>

Indiana law also provides that “[a] city, town, or county may not adopt an ordinance that restricts a person from providing emergency ambulance services in the city, town, township, or county if: [] the person is authorized to provide emergency ambulance services in any part of another county;<sup>282</sup> and [] the person has been requested to provide emergency ambulance services . . . .”<sup>283</sup>

## 15. Iowa

EMS in Iowa is governed by IOWA. CODE § 147A *et seq.* (titled “Emergency Medical Care – Trauma Care”).<sup>284</sup> Iowa’s EMS laws are administered and enforced by the Department of Health (“Department”).<sup>285</sup> The Emergency Medical Services Advisory Council (“Council”) is responsible for “advis[ing] advise the [Department] and develop[ing] policy recommendations concerning the regulation, administration, and coordination of emergency medical services in the state.”<sup>286</sup> The Council is comprised of various medical professionals appointed by the director of the Department.<sup>287</sup>

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<sup>281</sup> IND. CODE § 16-31-5-1.

<sup>282</sup> IND. CODE § 16-31-5-1(a).

<sup>283</sup> IND. CODE § 16-31-5-1(b).

<sup>284</sup> IOWA CODE § 147A *et seq.* (titled “Emergency Medical Care – Trauma Care”). Please note that all citations to IOWA CODE § 147A *et seq.* herein are current through legislation effective Apr. 30, 2021 from the 2021 Reg. Sess. (Westlaw Edge).

<sup>285</sup> IOWA CODE § 147A.1A (“The department is designated as the lead agency for coordinating and implementing the provision of emergency medical services in this state.”).

<sup>286</sup> IOWA CODE § 147A.2(2).

<sup>287</sup> IOWA CODE § 147A.2(1) (“Membership of the council shall be comprised of individuals nominated from, but not limited to, the following state or national organizations: Iowa osteopathic medical association, Iowa medical society, American college of emergency physicians, Iowa physician assistant society, Iowa academy of family physicians, university of Iowa hospitals and clinics, American academy of emergency medicine, American academy of pediatrics, Iowa EMS association, Iowa firefighters association, Iowa professional fire fighters, EMS education programs

Iowa law provides that a prospective EMS service program must apply to the Department “for authorization to establish a program for delivery of the care at the scene of an emergency, during transportation to a hospital, during transfer from one medical care facility to another or to a private residence, or while in the hospital emergency department, and until care is directly assumed by a physician or by authorized hospital personnel.”<sup>288</sup> Iowa’s EMS statutes and regulations do not indicate that EMS provider licenses are contingent (in whole or in part) on a determination that issuing the license is necessary for public benefit.

## 16. Kansas

EMS in Kansas is governed by KAN. STAT. § 65-61 *et seq.* (titled “Emergency Medical Services”).<sup>289</sup> Kansas’ EMS laws are administered and enforced by the Emergency Medical Services Board (“Board”).<sup>290</sup>

Kansas law provides that any municipality may establish an ambulance service:

The governing body of any municipality may establish, operate and maintain an emergency medical service or ambulance service . . . as a municipal function and may contract with any person, other municipality or board of a county hospital for the purpose of furnishing emergency medical services or ambulance services within or without the boundaries of the municipality upon such terms and conditions and for such compensation as may be agreed upon which shall be payable from the general fund of such municipality or from a special fund for which a tax is levied under the provisions of this act.<sup>291</sup>

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committee, Iowa nurses association, Iowa hospital association, and the Iowa state association of counties. The council shall also include at least two at-large members who are volunteer emergency medical care providers and a representative of a private service program.”).

<sup>288</sup> IOWA CODE § 147A.5.

<sup>289</sup> KAN. STAT. § 65-61 *et seq.* (titled “Emergency Medical Services”). Please note that all citations to KAN. STAT. § 65-61 *et seq.* herein are current through laws enacted during the 2021 Reg. Sess. of the Kansas Legislature effective on Apr. 29, 2021 (Westlaw Edge).

<sup>290</sup> KAN. STAT. §§ 65-6101– 65-6102.

<sup>291</sup> KAN. STAT. § 65-6113(a).

Such a local EMS system may be paid for by “an annual tax levy of not to exceed three mills upon all of the taxable tangible property within [the] municipality.”<sup>292</sup>

Municipalities that choose to operate an ambulance or other EMS service have several powers to implement the services:

In addition to other powers set forth in this act, the governing body of any municipality operating an emergency medical service or ambulance service shall have the power:

- (a) To acquire by gift, bequest, purchase or lease from public or private sources, and to plan, construct, operate and maintain the services, equipment and facilities which are incidental or necessary to the establishment, operation and maintenance of an emergency medical service or ambulance service;
- (b) to enter into contracts including, but not limited to, the power to enter into contracts for the construction, operation, management, maintenance and supervision of emergency medical services or ambulance services with any person or governmental entity;
- (c) to make application for and to receive any contributions, moneys or properties from the state or federal government or any agency thereof or from any other public or private source;
- (d) to contract or otherwise agree to combine or coordinate its activities, facilities and personnel with those of any person or governmental entity for the purpose of furnishing the emergency medical services or ambulance services within or without the municipality;
- (e) to establish and collect any charges to be made for emergency medical services or ambulance services within or without the municipality and to provide for an audit of the records of the emergency medical services operation or ambulance services; and
- (f) (f) to perform all other necessary and incidental functions necessary to accomplish the purposes of this act.<sup>293</sup>

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<sup>292</sup> KAN. STAT. § 65-6113(b).

<sup>293</sup> KAN. STAT. § 65-6116.



## 17. Kentucky

EMS in Kentucky is governed by KY. REV. STAT. § 311A *et seq.* (titled “Emergency Medical Services”).<sup>294</sup> Kentucky’s EMS laws are administered and enforced by the Board of Emergency Medical Services (“Board”), which is part of the Kentucky Community and Technical College System.<sup>295</sup> The Board is comprised of several medical professionals and public officials who are appointed by the governor.<sup>296</sup> Interestingly, one member must be a judge or county executive “from a county that operates . . . a licensed Class I ground ambulance service.”<sup>297</sup> The Board is responsible for issuing of all licenses under the state’s EMS statutes and regulations.<sup>298</sup> This includes the licensing of ambulance services.<sup>299</sup>

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<sup>294</sup> KY. REV. STAT. § 311A *et seq.* (titled “Emergency Medical Services”). Please note that all citations to KY. REV. STAT. § 311A *et seq.* herein are current through legislation effective Apr. 12, 2021 of the 2021 Reg. Sess. (Westlaw Edge).

<sup>295</sup> KY. REV. STAT. § 311A.015(1).

<sup>296</sup> KY. REV. STAT. § 311A.015(2) (“The board shall consist of thirteen [] members who are residents of Kentucky appointed by the Governor in conjunction with recognized state emergency medical services related organizations. Membership shall be made up of the following: (a) One [] emergency medical technician who works for a government agency but is not serving in an educational, management, or supervisory capacity; (b) One [] physician licensed in Kentucky serving as medical director of an advanced life support ambulance service selected from a list of three [] physicians submitted by the Kentucky Medical Association; (c) One [] physician licensed in Kentucky who is routinely involved in the emergency care of ill or injured children selected from a list of three [] physicians submitted by the Kentucky Medical Association; (d) One [] citizen having no involvement in the delivery of medical or emergency services; (e) One [] certified emergency medical services educator; (f) One [] fire-service-based, licensed Class I ground ambulance service administrator who is a certified emergency medical technician, an advanced emergency medical technician, or a licensed paramedic; (g) One [] licensed air ambulance service administrator or paramedic for a licensed air ambulance service headquartered in Kentucky; (h) One [] privately operated, licensed Class 1 ground ambulance service administrator who is a certified emergency medical technician, an advanced emergency medical technician, or a licensed paramedic; (i) One [] hospital administrator selected from a list of three (3) nominees submitted by the Kentucky Hospital Association; (j) One [] advanced life support ambulance provider who is an advanced emergency medical technician or a licensed paramedic, who works for a government agency but is not serving in an educational, management, or supervisory capacity; (k) One [] publicly operated Class I ground ambulance service administrator who is a certified emergency medical technician, an advanced emergency medical technician, or a licensed paramedic; (l) One [] mayor of a city that operates, either directly or through contract services, a licensed Class I ground ambulance service; and (m) One [] county judge/executive from a county that operates, whether directly or through contract services, a licensed Class I ground ambulance service.”).

<sup>297</sup> KY. REV. STAT. § 311A.015(2)(m).

<sup>298</sup> KY. REV. STAT. § 311A.020(1)(b) (“The board shall: . . . [] Issue any licenses or certifications authorized by this chapter”).

<sup>299</sup> KY. REV. STAT. § 311A.030.

Kentucky regulations provide that an ambulance service license applicant must submit an applicant, application fee, a “current map of the agency’s intended service area”, and a “written description of the ambulance agency’s geographic service area.”<sup>300</sup> However, Kentucky’s EMS statutes and regulations do not indicate that EMS provider licenses are contingent (in whole or in part) on a determination that issuing the license is necessary for public benefit, nor do they indicate that service areas may only be allocated to a single ambulance service provider.

## **18. Louisiana**

EMS in Louisiana is governed by LA. STAT. §§ 40:1131 – 40: 1139.5 (titled “Health Provisions: Emergency Medical Services”).<sup>301</sup> Louisiana’s EMS laws are administered and enforced by the Bureau of Emergency Medical Services (“Bureau”) within the Department of Health (“Department”).<sup>302</sup>

Louisiana law contains an interesting provision regarding commercial ambulance services:

No commercial ambulance shall make any emergency run based solely on information intercepted by use of a radio communication scanner or similar device except in cases where human life is threatened, unless that commercial ambulance has been specifically requested to respond to such emergency. Nothing in this Section shall be construed to prohibit service to a subscriber of a commercial ambulance service. . . .<sup>303</sup>

However, Louisiana statutes do not indicate that EMS provider licenses are contingent (in whole or in part) on a determination that issuing the license is necessary for public benefit, nor do they indicate that service areas may only be allocated to a single ambulance service provider.

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<sup>300</sup> 202 KY. ADMIN. REGS. 7:501(1).

<sup>301</sup> LA. STAT. §§ 40:1131 – 40: 1139.5 (titled “Health Provisions: Emergency Medical Services”). Please note that all citations to LA. STAT. §§ 40:1131 – 40: 1139.5 herein are current the 2020 Second Extraordinary Sess. (Westlaw Edge).

<sup>302</sup> LA. STAT. § 40:1131.1(E) (“The department shall promulgate and enforce such rules, regulations, and minimum standards as needed to carry out the provisions of this Section.”).

<sup>303</sup> LA. STAT. § 40:1135.7(A).

## 19. Maine

EMS in Maine is governed by 32 ME. STAT. § 81 *et seq.* (titled “Maine Emergency Medical Services Act of 1982”).<sup>304</sup> Maine’s EMS laws are administered and enforced by the Emergency Medical Services Board (“Board”).<sup>305</sup> The Board is comprised of various medical professionals appointed by the governor.<sup>306</sup> The Medical Direction and Practices Board (“Medical Direction Board”) is responsible for developing and implementing EMS treatment protocols.<sup>307</sup> The Board also delegates authority to regional EMS councils to carry out the state’s EMS laws.<sup>308</sup> In turn, the regional councils must implement an annual plan that is approved by the Board.<sup>309</sup>

## 20. Maryland

EMS in Maryland is governed by MD. CODE EDUC. § 13-501 *et seq.* (titled “Emergency Medical Services”).<sup>310</sup> Maryland’s EMS laws are administered and enforced by the Emergency Medical Services Board (“Board”) through the Institute for Emergency Medical Services Systems (“Institute”).<sup>311</sup> The Board is comprised of various medical professionals who are appointed by the

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<sup>304</sup> 32 ME. STAT. § 81 *et seq.* (titled “Maine Emergency Medical Services Act of 1982”). Please note that all citations to 32 ME. STAT. § 81 *et seq.* herein are current with legislation through Ch. 31 of the 2021 First Reg. Sess. of the 130th Legislature (Westlaw Edge).

<sup>305</sup> 32 ME. STAT. § 87 (“The Emergency Medical Services’ Board, as established by [5 ME. STAT. § 12004-A(15)] is responsible for the emergency medical services program.”).

<sup>306</sup> 32 ME. STAT. § 88(A)(1) (“The board has one member representing each region and 12 persons in addition. Of the additional persons, one is an emergency physician, one a representative of emergency medical dispatch providers, one a representative of the public, one a representative of for-profit ambulance services, one an emergency professional nurse, one a representative of nontransporting emergency medical services, one a representative of hospitals, one a fire chief, one a representative of a statewide association of fire chiefs, one a municipal emergency medical services provider, one a representative of not for-profit ambulance services and one a representative in the field of pediatrics. The members that represent for-profit ambulance services, nontransporting emergency medical services and not-for-profit ambulance services must be licensed emergency medical services persons. One of the nonpublic members must be a volunteer emergency medical services provider. . . Members are appointed by the Governor.”).

<sup>307</sup> 32 ME. STAT. § 88-B.

<sup>308</sup> 32 ME. STAT. § 89(1).

<sup>309</sup> 32 ME. STAT. § 89(2).

<sup>310</sup> MD. CODE EDUC. § 13-501 *et seq.* (titled “Emergency Medical Services”). Please note that all citations to MD. CODE EDUC. § 13-501 *et seq.* herein are current with emergency legislation effective through Apr. 13, 2021, from the 2021 Reg. Sess. of the General Assembly (Westlaw Edge).

<sup>311</sup> MD. CODE EDUC. § 13-508 (listing the Board’s powers and duties).

governor.<sup>312</sup> The governor is prohibited from appointing more than two people from the same health system, health system and affiliated medical school, or medical schools under the same governing board.<sup>313</sup> The Emergency Medical Services Advisory Council (“Council”) is responsible for assisting the Board in its functions.<sup>314</sup> The Council is comprised of more than two dozen medical professionals who are appointed by their respective professional associations, subject to the governor’s approval.<sup>315</sup>

The Board is required to develop and adopt a statewide EMS plan.<sup>316</sup> The Board is also required to regulate the licensing of ambulance services in the state.<sup>317</sup> Maine law does not stipulate that ambulance service licensing is contingent (in whole or in part) on a determination that issuing the license is necessary for public benefit, nor does the law indicate that service areas may only be allocated to a single ambulance service provider.

## **21. Massachusetts**

EMS in Massachusetts is governed by MASS. GEN. LAWS ch. 111C (titled “Emergency Medical Services System”).<sup>318</sup> Massachusetts’ EMS laws are administered and enforced by the Department of Public Health (“Department”).<sup>319</sup> Regional EMS councils must adopt a service zone plan “that identifies, coordinates and makes optimal use of all available EMS resources within each service zone.”<sup>320</sup> Such service zone plans must include, among other things, a selection process for local jurisdictions:

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<sup>312</sup> MD. CODE EDUC. § 13-505(a)(1)–(2) (listing the Council’s various members).

<sup>313</sup> MD. CODE EDUC. § 13-505(b)(4).

<sup>314</sup> MD. CODE EDUC. § 13-511(a).

<sup>315</sup> MD. CODE EDUC. § 13-511(b).

<sup>316</sup> MD. CODE EDUC. § 13-509.

<sup>317</sup> MD. CODE EDUC. § 13-515(c)(1).

<sup>318</sup> MASS. GEN. LAWS ch. 111C (titled “Emergency Medical Services System”). Please note that all citations to MASS. GEN. LAWS ch. 111C herein are current through Ch. 8 of the 2021 First Annual Sess. (Westlaw Edge).

<sup>319</sup> MASS. GEN. LAWS ch. 111C § 1 (“The department shall promulgate rules and regulations to carry out the provisions of this chapter and may further define in such rules and regulations any term used in this chapter . . .”).

<sup>320</sup> MASS. GEN. LAWS ch. 111C § 10(a).

Each service zone plan shall include, without limitation, the following: . . . a selection process, to be carried out by a local jurisdiction whenever a local jurisdiction within a service zone proposes an upgrade in level of service that a service zone provider is unable to provide or whenever a downgrade of a service zone’s level of services is proposed or effected, including, without limitation, selection criteria, to be used by service zones within the region in selecting a service zone provider. Selection criteria may vary among service zones, but shall include, without limitation, standards concerning response time, staffing requirements, deployment of resources, adequate backup, level of service, medical control, facility destinations and other factors promoting the optimal utilization of all available EMS resources[.]<sup>321</sup>

Massachusetts law also provides that “[n]o ambulance service shall provide primary ambulance response in a service zone, unless it is the designated primary ambulance service.”<sup>322</sup>

## **22. Michigan**

EMS in Michigan is governed by MICH. COMP. L. § 333.209 *et seq.* (titled “Emergency Medical Services”).<sup>323</sup> Michigan’s EMS laws are administered and enforced by the Bureau of Emergency Medical Services Trauma and Preparedness (“Bureau”) within the Department of Health & Human Services (“Department”).<sup>324</sup> The Emergency Medical Services Coordination Committee (“Committee”) is responsible for, among other things, advising the Department on various aspects of EMS and commenting on regulations proposed by the Board.<sup>325</sup>

While the Department administers Michigan’s EMS system broadly at the state level, Michigan’s EMS system is substantially decentralized, as the Department designates Medical

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<sup>321</sup> MASS. GEN. LAWS ch. 111C § 10(a)(3).

<sup>322</sup> MASS. GEN. LAWS ch. 111C § 10(d).

<sup>323</sup> MICH. COMP. L. § 333.209 *et seq.* (titled “Emergency Medical Services”). Please note that all citations to MICH. COMP. L. § 333.209 *et seq.* herein are current through P.A. 2021, No. 6, of the 2021 Reg. Sess., 101st Legislature (Westlaw Edge).

<sup>324</sup> MICH. COMP. L. § 333.20910.

<sup>325</sup> MICH. COMP. L. § 333.20915(1) (establishing the EMSCC); MICH. COMP. L. § 333.20916 (articulating the duties of the EMSCC).

Control Authorities (“MCAs”) to coordinate and supervise local EMS systems throughout the state at the county level:

The department shall designate a medical control authority for each Michigan county or part of a county, except that the department may designate a medical control authority to cover 2 or more counties if the department and affected medical control authorities determine that the available resources would be better utilized with a multiple county medical control authority. In designating a medical control authority, the department shall assure that there is a reasonable relationship between the existing emergency medical services capacity in the geographical area to be served by the medical control authority and the estimated demand for emergency medical services in that area.<sup>326</sup>

These MCAs are administered by participating hospitals that meet certain requirements.<sup>327</sup>

In turn, the participating hospitals must appoint an advisory board that must include “a representative of each type of life support agency and each type of emergency medical services personnel functioning within the medical control authority’s boundaries.”<sup>328</sup> Licensed EMS agencies are accountable to the local MCA under the MCA’s protocols.<sup>329</sup>

Michigan law specifically provides that local governmental units may establish an ambulance service:

A local governmental unit or combination of local governmental units may operate an ambulance operation or a nontransport prehospital life support operation, or contract with a person to furnish any of those services for the use and benefit of its residents, and may pay for any or all of the cost from available funds. A local

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<sup>326</sup> MICH. COMP. L. § 333.20918(1).

<sup>327</sup> MICH. COMP. L. § 333.20918(1) (“Each hospital licensed under part 2151 and each freestanding surgical outpatient facility licensed under part 2082 that operates a service for treating emergency patients 24 hours a day, 7 days a week and meets standards established by medical control authority protocols shall be given the opportunity to participate in the ongoing planning and development activities of the local medical control authority designated by the department and shall adhere to protocols for providing services to a patient before care of the patient is transferred to hospital personnel, to the extent that those protocols apply to a hospital or freestanding surgical outpatient facility . . . .”); MICH. COMP. L. § 333.20918(2) (“A medical control authority shall be administered by the participating hospitals . . . .”).

<sup>328</sup> MICH. COMP. L. § 333.20918(2) (“[T]he participating hospitals shall appoint an advisory body for the medical control authority . . . .”).

<sup>329</sup> MICH. COMP. L. § 333.20918(6).

governmental unit may receive state or federal funds or private funds for the purpose of providing emergency medical services.<sup>330</sup>

### **23. Minnesota**

Please refer to Minnesota’s EMS Statutes and Regulations *infra* Section II p. 13–27 for a detailed overview of Minnesota’s EMS statutes and regulations.

### **24. Mississippi**

EMS in Mississippi is governed by MISS. CODE § 41-50 *et seq.* (titled “Emergency Medical Services Act of 1974”).<sup>331</sup> Mississippi’s EMS laws are administered and enforced by the Board of Health (“Board”) through the Office of Emergency Planning and Response within the Department of Health (“Department”).<sup>332</sup> The Emergency Medical Services Advisory Council (“Council”) is responsible for advising the Board on aspects of EMS.<sup>333</sup> The Council is comprised of various medical professionals appointed by the governor.<sup>334</sup> Mississippi law provides that ambulance service licensee applications must include, among other things, a “[t]he location and description of the place or places from which the ambulance service is intended to operate[.]”<sup>335</sup> However, Mississippi law does not stipulate that ambulance service licensing is contingent (in whole or in part) on a determination that issuing the license is necessary for public benefit, nor does the law indicate that service areas may only be allocated to a single ambulance service provider.

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<sup>330</sup> MICH. COMP. L. § 333.20948(1).

<sup>331</sup> MISS. CODE § 41-59 *et seq.* (titled “Emergency Medical Services Act of 1974”). Please note that all citations to MISS. CODE § 41-59 *et seq.* herein are current with laws from the 2021 Reg. Sess. effective Apr. 20, 2021 (Westlaw Edge).

<sup>332</sup> MISS. CODE § 41-59-5 (articulating the roles of the Board and Department, respectively).

<sup>333</sup> MISS. CODE § 41-59-7(1) (“The advisory council shall advise and make recommendations to the board regarding rules and regulations promulgated pursuant to this chapter.”).

<sup>334</sup> *Id.*

<sup>335</sup> MISS. CODE § 41-59-11(d).

## 25. Missouri

EMS in Missouri is governed by MO. REV. STAT. § 190.001 *et seq.* (titled “Comprehensive Emergency Medical Services Systems Act”).<sup>336</sup> The statute provides for the creation of ambulance districts under the purview of the Department of Health and Senior Services (“Department”).<sup>337</sup> Each ambulance district becomes a “body corporate” and political subdivision of the state, which “shall be known as “[Insert Name] Ambulance District”, and in that name may sue and be sued, levy and collect taxes within the limitations of [MO. REV. STAT. §§ 190.001–190.090] and the constitution and issue bonds as provided in [MO. REV. STAT. §§ 190.001–190.090].”<sup>338</sup> Within each district, elections are held for the “directors of the ambulance.”<sup>339</sup> The directors of the ambulance are the ambulance authority for each district.<sup>340</sup>

Special powers are delegated to the districts by statute. The powers are, in essence, those that are required to fulfill the purpose to “establish and maintain ambulance service within its corporate limits.”<sup>341</sup> Each district is charged:

To operate, maintain and manage the ambulance service, and to make and enter into contracts for the use, operation or management of and to provide rules and regulations for the operation, management or use of the ambulance service[.]<sup>342</sup>

The powers delegated to ambulance districts also include those necessary:

To maintain the ambulance service for the benefit of the inhabitants of the area comprising the district regardless of race, creed or color, and to adopt such reasonable rules and regulations as may be necessary to render the highest quality of emergency medical care;

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<sup>336</sup> MO. REV. STAT. § 190.001 *et seq.* (titled “Comprehensive Emergency Medical Services Systems Act”). Please note that all citations to MO. REV. STAT. § 190.001 *et seq.* herein are current through the end of the 2020 Second Reg. Sess. and First and Second Extraordinary Sessions of the 100th General Assembly (Westlaw Edge).

<sup>337</sup> MO. REV. STAT. § 190.010.

<sup>338</sup> *Id.*

<sup>339</sup> MO. REV. STAT. § 190.050 (West, Westlaw Edge through the end of the 2020 Second Regular Session and First and Second Extraordinary Sessions of the 100th General Assembly).

<sup>340</sup> *Id.*

<sup>341</sup> MO. REV. STAT. § 190.060.

<sup>342</sup> MO. REV. STAT. § 190.060(1)(3).



to exclude from the use of the ambulance service all persons who willfully disregard any of the rules and regulations so established; to extend the privileges and use of the ambulance service to persons residing outside the area of the district upon such terms and conditions as the board of directors prescribes by its rules and regulations[.]<sup>343</sup>

Missouri's Comprehensive Emergency Medical Systems Act, like most states, prohibits ambulance services without the appropriate license that has been granted by the department.<sup>344</sup> Though providers must be licensed by the department, the statute also explicitly addresses that the statute is not intended "to limit or supersede the powers given to ambulance districts pursuant to this chapter."<sup>345</sup>

Missouri's EMS system is quite different from that of Minnesota. Although licensing happens at the state level, the state has created various ambulance districts in the state which are political subdivisions, with elected leaders, that manage the ambulance services within the boundaries of each district. Therefore, the ambulance districts are the authority for determining how services areas and ambulance providers are distributed within each district's territory.

## **26. Montana**

EMS in Montana is governed by MONT. CODE § 50-6 *et seq.* (titled "Emergency Medical Services").<sup>346</sup> The EMS system in Montana is established and administered by the Department of Public Health and Human Services ("Department").<sup>347</sup> The Department issues licenses for specific types of EMS.<sup>348</sup> A board of medical examiners establishes care standards at the state level.<sup>349</sup> There is also a statewide advisory committee that consists of a physician appointed by the

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<sup>343</sup> MO. REV. STAT. § 190.060(1)(7).

<sup>344</sup> MO. REV. STAT. § 190.105(1).

<sup>345</sup> MO. REV. STAT. § 190.105(13).

<sup>346</sup> MONT. CODE § 50-6 *et seq.* (titled "Emergency Medical Services"). Please note that all citations to MONT. CODE § 50-6 *et seq.* herein are current through Mar. 26, 2021 (Lexis Advance).

<sup>347</sup> MONT. CODE § 50-6-102.

<sup>348</sup> MONT. ADMIN. R. 37.104.105 (Lexis Advance through April 17, 2021).

<sup>349</sup> MONT. CODE § 50-6-105.

department and one representative of each type and level of service licensed in the statute.<sup>350</sup>

Neither the relevant EMS statute nor regulations in Montana address how ambulance service areas are distributed in the state.

## **27. Nebraska**

EMS in Nebraska is governed by NEB. REV. STAT. §§ 38-1201–38-1237 (titled “Emergency Medical Services Practice Act”).<sup>351</sup> Ambulance service licensing is conducted through the Department of Health and Human Services (“Department”).<sup>352</sup> There is also a statewide Board of Emergency Medical Services (“Board”).<sup>353</sup> The Board is responsible for creating licensure requirements, recommending the issuance of licenses, and ensuring that standards are being met.<sup>354</sup>

## **28. Nevada**

EMS in Nevada is governed by NEV. REV. STAT. § 450B.010 *et seq.* (titled “Emergency Medical Services”).<sup>355</sup> The EMS system is operated within the Division of Public and Behavioral Health of the Department of Health and Human Services.<sup>356</sup> The statute grants authority to the State Board of Health to establish and promulgate rules, regulations, standards and procedures as are necessary to administer the EMS statute.<sup>357</sup> “Board” means the State Board of Health in counties whose population is less than 700,000 and the district board of health in counties whose

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<sup>350</sup> MONT. ADMIN. R. 37.104.120 Lexis Advance through April 17, 2021) (“selected from a group of individuals who have expressed an interest in serving on the committee and who have completed and returned the forms specified by the department, with adequate consideration to demographics and geographics”).

<sup>351</sup> NEB. REV. STAT. §§ 38-1201 – 38-1237 (titled “Emergency Medical Services Practice Act”). Please note that all citations to NEB. REV. STAT. §§ 38-1201 – 38-1237 herein are current through Acts of the First Reg. Sess. of the 107th Legislature (2021) (Lexis Advance).

<sup>352</sup> *Id.*

<sup>353</sup> NEB. REV. STAT. § 38-1206.

<sup>354</sup> NEB. REV. STAT. § 38-1217.

<sup>355</sup> NEV. REV. STAT. § 450B.010 *et seq.* (titled “Emergency Medical Services”). Please note that all citations to NEV. REV. STAT. § 450B.010 *et seq.* herein are current through Ch. 3 of the 81st Reg. Sess. (2021), including all legislation effective Mar. 28, 2021 (Lexis Advance).

<sup>356</sup> NEV. REV. STAT. § 450B.0625.

<sup>357</sup> NEV. REV. STAT. § 450B.120.

population is 700,000 or more.<sup>358</sup> There is a committee on Emergency Medical Services, created by the State Board of Health.<sup>359</sup> One duty of the committee is to “Review and advise the Division regarding the management and performance of emergency medical services in this State and regarding statewide emergency medical protocols.”<sup>360</sup>

The appropriate health authority may issue a permit for the operation of an ambulance or an air ambulance.<sup>361</sup> Although the permit process does not explicitly address primary service areas, one requirement on the application for a permit is to contain “The location and description of the places from which the ambulance, air ambulance or fire-fighting agency intends to operate[.]”<sup>362</sup> The statute also specifies, notably, that “The issuance of a permit pursuant to this section or NRS 450B.210 does not authorize any person or governmental entity to provide those services or to operate any ambulance . . . not in conformity with any ordinance or regulation enacted by any county, municipality or special purpose district.”<sup>363</sup> All local ordinances and regulations are superseded, “except those local ordinances and regulations which are more stringent than the regulations provided for in this section.”<sup>364</sup> The regulations clarify that a local authority may “grant a variance” to the provisions of the chapter.<sup>365</sup> Therefore, the statute explicitly addresses that local government regulations may provide an additional level of ambulance service regulation. However, despite Nevada’s extensive system outlined in the statute and regulations, there is no reference to primary service areas.

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<sup>358</sup> NEV. REV. STAT. § 450B.060.

<sup>359</sup> NEV. REV. STAT. § 450B.120.

<sup>360</sup> NEV. REV. STAT. § 450B.153.

<sup>361</sup> NEV. REV. STAT. § 450B.200(1)(a).

<sup>362</sup> NEV. REV. STAT. § 450B.200(4)(d).

<sup>363</sup> NEV. REV. STAT. § 450B.200(10).

<sup>364</sup> NEV. REV. STAT. § 439.200.

<sup>365</sup> NEV. ADMIN. CODE § 450B.295 (Lexis Advance through August 2020).

## 29. New Hampshire

EMS in New Hampshire is governed by N.H. REV. STAT. §§ 153-A:1–153-A:36 (titled “Emergency Medical and Trauma Services”).<sup>366</sup> At the highest level, the commissioner of public health is responsible for the statewide supervision of emergency medical services.<sup>367</sup> At the statewide level, there is also a medical control board which assists with standards, services, protocols, etc.<sup>368</sup> The governing statute also creates a statewide emergency medical and trauma services board (“EMTSB”).<sup>369</sup> One statutory duty of the EMTSB is to “Designate emergency medical services regions and districts in the state, in accordance with RSA 153-A:6. The council established for a region shall include a New Hampshire licensed physician with a background in emergency medicine.”<sup>370</sup> The statutory provision which specifically governs EMS districts and regions states:

The coordinating board shall delineate emergency medical services regions and districts and shall establish councils to oversee each designated area. The coordinating board shall assure that each council meets its responsibilities in a manner consistent with the emergency medical care needs of the area it serves. The council established for a region shall include a licensed, board-certified emergency physician or a licensed physician experienced in emergency medicine. The director shall implement the provisions of this section.<sup>371</sup>

The regulations specify that there will be a minimum of three EMS regional councils designated by the coordinating board.<sup>372</sup> In New Hampshire, EMS providers are called Emergency

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<sup>366</sup> N.H. REV. STAT. §§ 153-A:1 – 153-A:36 (titled “Emergency Medical and Trauma Services”). Please note that all citations to N.H. REV. STAT. §§ 153-A:1 – 153-A:36 herein are current through Ch. 2 of the 2021 Reg. Sess. (Lexis Advance).

<sup>367</sup> N.H. REV. STAT. § 153-A:7(I).

<sup>368</sup> N.H. REV. STAT. § 153-A:5.

<sup>369</sup> N.H. REV. STAT. § 153-A:3(I).

<sup>370</sup> N.H. REV. STAT. § 153-A:4(V).

<sup>371</sup> N.H. REV. STAT. § 153-A:6.

<sup>372</sup> N.H. CODE R. SAF-C 5902.01 (Lexis Advance through April 2, 2021).

Medical Service Units (“Units”),<sup>373</sup> and are required to obtain a license. Units must agree, in order to be certified, to “operate in accordance with all applicable local ordinances regarding emergency medical services.”<sup>374</sup> Although there is no reference to primary service areas for units, each unit is required to have a valid written agreement with only one hospital to serve as its medical resource hospital (“MRH”).<sup>375</sup> The designation of an MRH is made on the basis “of the hospital being geographically located nearest to the population served by the unit or which receives the majority of the unit's patients.”<sup>376</sup>

### **30. New Jersey**

EMS in New Jersey is governed by N.J. STAT. § 26:2K *et. seq.*<sup>377</sup> The governing statute delegates authority to the Department of Health (“Department”), through the commissioner, to adopt rules pertaining to the operation of programs and services providing advanced life support care.<sup>378</sup> In 1967, New Jersey created the Office of Emergency Medical Services (“OEMS”), which was the first of its kind in the United States. The statute also specifies a particular rule regarding hospitals’ ability to provide ALS and BLS:

A hospital which has been issued a certificate of need by the Department of Health to operate a Level 1 trauma center shall be exclusively authorized to develop and maintain advanced life support services in the municipality in which the trauma center is located, and shall have the right of first refusal to provide both advanced life support and basic life support services in the municipality, provided that the services are provided at no charge to the municipality, and the municipality does not provide basic life support services as a municipal service or as part of a shared services agreement.<sup>379</sup>

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<sup>373</sup> N.H. REV. STAT. § 153-A:2.

<sup>374</sup> N.H. CODE R. SAF-C 5903.03 (Lexis Advance through April 2, 2021).

<sup>375</sup> N.H. CODE R. SAF-C 5902.02(a) (Lexis Advance through April 2, 2021).

<sup>376</sup> N.H. CODE R. SAF-C 5902.02 (Lexis Advance through April 2, 2021).

<sup>377</sup> N.J. Stat. § 26:2K-7.

<sup>378</sup> *Id.*

<sup>379</sup> N.J. Stat. § 26:2K-12.1.

The New Jersey Administrative Code extensively addresses licensing requirements and operations of EMS in chapter 40 (BLS) and chapter 41 (ALS).<sup>380</sup> However, there is no explicit mention of services areas except in addressing mobile intensive care programs (“MICP”).<sup>381</sup> Mobile Intensive Care Units (“MICU”) must follow the service area designations as determined by the certificate of need.<sup>382</sup>

### **31. New Mexico**

EMS in New Mexico is governed by N.M. STAT. §§ 24-10B-1–24-10B-13 (titled “Emergency Medical Services Act”).<sup>383</sup> The Emergency Medical Systems Bureau (“Bureau”), through the Department of Health (“Department”), is the lead agency for establishing the emergency medical services system.<sup>384</sup> One of the Bureau’s statutory duties is to adopt rules for the administration of certification programs.<sup>385</sup> Licensure is conducted by the Emergency Medical Services Licensing Commission (“Commission”), which is staffed by the Bureau.<sup>386</sup> The Bureau is also advised by a statewide EMS advisory committee.<sup>387</sup>

The state is divided into three EMS regions.<sup>388</sup> In New Mexico, the public regulation commission regulates ambulances as a public utility. In regulating ambulance service, service areas are addressed in the governing statute by specifying, “before granting a certificate for

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<sup>380</sup> See N.J. ADMIN. CODE § 8:40 *et seq.*; N.J. ADMIN. CODE § 8:41 *et seq.* (Lexis Advance through the N.J. Reg., Vol. 53 No. 8, Apr. 19, 2021).

<sup>381</sup> N.J. ADMIN. CODE § 8:41-9.1 (Lexis Advance through the N.J. Reg., Vol. 53 No. 8, Apr. 19, 2021).

<sup>382</sup> N.J. ADMIN. CODE § 8:41-1.3 (“Certificate of need” means the formal written approval of the New Jersey Department of Health and Senior Services to construct or expand a health care facility or to institute a new health care service, in accordance with requirements set forth in N.J.A.C. 8:33”) (Lexis Advance through the N.J. Reg., Vol. 53 No. 8, Apr. 19, 2021).

<sup>383</sup> N.M. STAT. §§ 24-10B-1 – 24-10B-13 (titled “Emergency Medical Services Act”). Please note that all citations to N.M. STAT. §§ 24-10B-1 – 24-10B-13 herein are current through Ch. 6 of the First Reg. Sess. of the 55th Legislature (2021) (Lexis Advance).

<sup>384</sup> N.M. STAT. § 24-10B-4.

<sup>385</sup> N.M. STAT. § 24-10B-4(L).

<sup>386</sup> N.M. STAT. § 24-10B-5.1.

<sup>387</sup> N.M. STAT. § 24-10B-7(A).

<sup>388</sup> See *Emergency Medical Services Region Websites*, N.M. DEP’T OF HEALTH (last visited May 12, 2021), <https://www.nmhealth.org/about/erd/emsb/region/>.

ambulance service, the commission shall also consider the effect that issuance of the certificate would have on existing ambulance service in the territory.”<sup>389</sup> The rules specify that the issuance of a permit to an ambulance service must specify the territory to be served or patient catchment area (if different from the territory to be served).<sup>390</sup>

Each ambulance service requires a written operations plan which is inspected by the bureau.<sup>391</sup> The operations plans must detail policies and procedures, including response times in the ambulance service’s territory or patient catchment area.<sup>392</sup> The discussion of factors that affect response times include geography of the territory, stationing points, weather, and whether the territory is urban or rural.<sup>393</sup>

### **32. New York**

EMS in New York is governed by N.Y. PUB. HEALTH L. §§ 3000–3032 (titled “Emergency Medical Services”).<sup>394</sup> New York’s EMS laws are administered and enforced by the Department of Health (“Department”). There is also an Emergency Medical Services Council (“Council”) to create rules and regulations for ambulance service certification, as well as provision of ambulance services outside the primary territory specified in ambulance services’ certificate.<sup>395</sup> There are also regional councils designated by the commissioner of health, which cannot exceed eighteen.<sup>396</sup> Councils were approved based on applications from local organizations and include a description

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<sup>389</sup> N.M. STAT. § 65-2A-8.

<sup>390</sup> *Id.*

<sup>391</sup> N.M. CODE R. § 18.3.14.10 (Lexis Advance through N.M. Reg., Vol. XXXII, No. 7, dated Apr. 6, 2021).

<sup>392</sup> N.M. CODE R. § 18.3.14.10(I) (Lexis Advance through N.M. Reg., Vol. XXXII, No. 7, dated Apr. 6, 2021).

<sup>393</sup> *Id.*

<sup>394</sup> N.Y. PUB. HEALTH L. §§ 3000 – 3032 (titled “Emergency Medical Services”). Please note that all citations to N.Y. PUB. HEALTH L. §§ 3000 – 3032 herein are current through 2021 released Ch. 1–49, 61–101 (Lexis Advance).

<sup>395</sup> N.Y. PUB. HEALTH L. § 3002(2).

<sup>396</sup> N.Y. PUB. HEALTH L. § 3003(1).

of the geographic area to be served.<sup>397</sup> Each regional council coordinates EMS programs within its region and enters into contracts for the performance of its duties.<sup>398</sup>

Every ambulance service certificate or statement of registration must specify the primary territory within which the ambulance service is permitted to operate.<sup>399</sup> Ambulance companies may only receive patients from within its primary territory (with exceptions).<sup>400</sup> A service cannot operate without approval from the regional council and cannot transfer or serve other regions without going through the appropriate procedure.<sup>401</sup> Interfacility transfers are not bound by these rules, as the statute states that an ambulance service “owned by or under contract to a general hospital licensed by the department may transport any specialty patient from any other general hospital or health care facility licensed by the department to the hospital owning such ambulance service, or with which it has a contract.”<sup>402</sup>

### **33. North Carolina**

EMS in North Carolina is governed by N.C. GEN. STAT. § 143-507 *et seq.* (titled “Emergency Medical Services Act of 1973”).<sup>403</sup> The statute establishes a Statewide Emergency Medical Services System in the Department of Health and Human Services (“Department”).<sup>404</sup> The Department secretary of may “develop and implement, in conjunction with any local sponsors that may agree to participate, regional emergency medical services systems in order to demonstrate the desirability of comprehensive regional emergency medical services systems and to determine

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<sup>397</sup> N.Y. PUB. HEALTH L. § 3003(2).

<sup>398</sup> N.Y. PUB. HEALTH L. § 3003(3).

<sup>399</sup> N.Y. PUB. HEALTH L. § 3010(1).

<sup>400</sup> *Id.*

<sup>401</sup> N.Y. PUB. HEALTH L. § 3003(2).

<sup>402</sup> N.Y. PUB. HEALTH L. § 3010.

<sup>403</sup> N.C. GEN. STAT. § 143-507 *et seq.* (titled “Emergency Medical Services Act of 1973”). Please note that all citations to N.C. GEN. STAT. § 143-507 *et seq.* herein are current through Sess. L. 2021-6 of the 2021 Reg. Sess. of the General Assembly (Lexis Advance).

<sup>404</sup> N.C. GEN. STAT. § 143-507(a).



the optimum characteristics of such plans.”<sup>405</sup> This may include the establishment of emergency medical services regional councils to implement and coordinate EMS programs within regions.<sup>406</sup> There is also an EMS advisory council, created to advise the secretary of DHHS.<sup>407</sup>

Regarding service areas and regions, the statute specifies that the secretary of the Department may establish “an appropriate number of multicounty emergency medical services regions.”<sup>408</sup> The relevant regulations specify that county governments shall establish EMS systems that are required to have:

A defined geographical service area for the EMS System. The minimum service area for an EMS System shall be one county. There may be multiple EMS Provider service areas within an EMS System. The highest level of care offered within any EMS Provider service area shall be available to the citizens within that service area 24 hours a day, seven days a week[.]<sup>409</sup>

North Carolina’s statute specifies the role of counties in the EMS system by stating “[e]ach county shall ensure that emergency medical services are provided to its citizens. Nothing in this Article affects the power of local governments to finance ambulance operations or to support rescue squads.”<sup>410</sup>

### **34. North Dakota**

EMS in North Dakota is governed by N.D. CENT. CODE §§ 23-27-01 – 23-27-05.<sup>411</sup> The statute states that the Department of Health (“Department”) is tasked with licensing emergency medical services operations and “may designate their service areas.”<sup>412</sup> The Department “shall

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<sup>405</sup> N.C. GEN. STAT. § 143-512.

<sup>406</sup> N.C. GEN. STAT. § 143-513.

<sup>407</sup> N.C. GEN. STAT. § 143-510(a).

<sup>408</sup> N.C. GEN. STAT. § 143-515.

<sup>409</sup> 10A N.C. ADMIN. CODE 13P.0201(1)(a) (Lexis Advance through issue 35:19 N.C. Reg., Apr. 1, 2021).

<sup>410</sup> N.C. GEN. STAT. § 143-517.

<sup>411</sup> N.D. CENT. CODE §§ 23-27-01 – 23-27-05. Please note that all citations to N.D. CENT. CODE §§ 23-27-01 – 23-27-05 herein are current through all emergency acts approved by the governor through Mar. 23, 2021, during the 2021 Reg. Legislative Sess. (Lexis Advance).

<sup>412</sup> N.D. CENT. CODE § 23-27-01(1).

limit the issuance of a license for any new emergency medical services operation based on the needs of the service area.”<sup>413</sup>

North Dakota also specifies in the governing statute that any county or municipality may, by itself or in combination any other county of municipality within the state:

[E]stablish, maintain, contract for, or otherwise provide emergency medical service for such county or municipality; and for this purpose, out of any funds of such county or municipality not otherwise committed, may buy, rent, lease, or otherwise contract for all such vehicles, equipment, or other facilities or services which may be necessary to effectuate such purpose.”<sup>414</sup>

A unique feature of North Dakota’s EMS system is that there is a process for creating “rural ambulance service districts.”<sup>415</sup> When a rural community is “not presently served by an existing emergency medical service,” that community may “elect to form, organize, establish, equip, and maintain a rural ambulance service district.”<sup>416</sup> The process of creating a district requires petitioning to the county auditor the plan of the proposed district and requires that the petitioners include a plat or map showing the suggested boundaries of the proposed district.<sup>417</sup> To be created, the proposed rural ambulance district must be screened by the county auditor and submitted to a vote at the next countywide election.<sup>418</sup> If the district is created, a board of directors is elected and policy established for the district.

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<sup>413</sup> *Id.*

<sup>414</sup> N.D. CENT. CODE § 23-12-08.

<sup>415</sup> N.D. CENT. CODE § 11-28.3-01.

<sup>416</sup> *Id.*

<sup>417</sup> *Id.*

<sup>418</sup> N.D. Cent. Code § 11-28.3-06 (Lexis Advance through all emergency effective Acts approved by the governor through March 23, 2021, during the 2021 Regular Legislative Session).

### 35. Ohio

EMS in Ohio is governed by OHIO REV. CODE §§ 4765–4766.<sup>419</sup> The Board of Emergency Medical, Fire, and Transportation Services (“Board”) issues a certification of licensure to an emergency medical service organization.<sup>420</sup> The Board is an entity of the Division of Emergency Medical Services (“Division”) within the Department of Public Safety (“Department”).<sup>421</sup> The Board divides the state into prehospital emergency medical services regions “for purposes of overseeing the delivery of adult and pediatric prehospital emergency medical services.”<sup>422</sup> Each region is overseen by a regional director or regional advisory board that is appointed by the board.<sup>423</sup> In 2015, Ohio was divided into eight geographic regions.<sup>424</sup>

Ohio gives specific powers to the boards of county commissioners and to municipalities. A board of county commissioners, by appropriate resolution, may choose to have the Board license any EMS organization the board of county commissioners operates.<sup>425</sup> A board may also remove its EMS organization from the jurisdiction of the Board.<sup>426</sup> By statute, the boards of county commissions of two or more counties may “create a joint emergency medical services district for the purpose of providing emergency medical services to the district.”<sup>427</sup>

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<sup>419</sup> OHIO REV. CODE §§ 4765 – 4766 Please note that all citations to OHIO REV. CODE §§ 4765 – 4766 herein are current through File 8 of the 134th (2021-2022) General Assembly; all acts passed as of Apr. 10, 2021 (Lexis Advance).

<sup>420</sup> OHIO ADMIN. CODE 4766-2-01(I) (Lexis Advance through updates effective Mar. 15, 2021) (which may also be called a Medical Transportation Organization (“MTO”).

<sup>421</sup> OHIO REV. CODE § 4765.02(A)(1).

<sup>422</sup> OHIO REV. CODE § 4765.05(B).

<sup>423</sup> *Id.*

<sup>424</sup> OHIO ADMIN. CODE 4765-3-01(B) (Lexis Advance through updates effective Mar. 15, 2021).

<sup>425</sup> OHIO REV. CODE § 307.051.

<sup>426</sup> *Id.*

<sup>427</sup> OHIO REV. CODE § 307.052.

### 36. Oklahoma

EMS in Oklahoma is governed at the constitutional level by OKLA. CONST. art. X, § 9C.<sup>428</sup>

The constitutional provision allows for EMS districts to be created across the state. The process of forming EMS districts involves the board of county commissioners, or boards if more than one county is involved, which may call a special election to determine whether or not an ambulance service district shall be formed.<sup>429</sup> The provision further clarifies, “[s]aid area may embrace a county, a part thereof, or more than one county or parts thereof, and in the event the area covers only a part or parts of one or more counties, the area must follow school district boundary lines.”<sup>430</sup> In lieu of the proceeding process, the governing body of an incorporated city or town may form a district, join an existing district, or form a district with other cities or towns.<sup>431</sup> In this model, the governing body is substituted as to the powers and duties of the county commissioners in the district model and the rights, duties, privileges, and obligations of residents in such city or town is the same as those within a created ambulance district.<sup>432</sup>

Oklahoma statute clarifies that when a district is totally within the municipal city limits of a city, the board of directors of the district or their designee may be the governing body of the city or town.<sup>433</sup> Additionally, the board of county commissioners of each county has the power, and the duty, to incorporate and order the creation of ambulance districts when a proper petition has been filed.<sup>434</sup> The requirements of a petition to incorporate a district requires a description of the area proposed to be served within the district, as well as an attached map or plat of the area.<sup>435</sup>

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<sup>428</sup> OKLA. CONST. art. X, § 9C.

<sup>429</sup> OKLA. CONST. art. X, § 9C.

<sup>430</sup> *Id.*

<sup>431</sup> OKLA. CONST. art. X, § 9C(p).

<sup>432</sup> *Id.*

<sup>433</sup> OKLA. STAT. tit. 19, § 1203(a).

<sup>434</sup> OKLA. STAT. tit. 19, § 12039(b).

<sup>435</sup> OKLA. STAT. tit. 19, § 1204(b).

There is also a process by which an area outside the boundaries of any district can be annexed and served by the district, through the appropriate petition which demonstrates that the area is without an adequate system and that annexation will promote public health, safety, and welfare of residents in the area.<sup>436</sup>

Oklahoma’s EMS program is administered through the Division of Emergency Medical Services (“Division”) within the Department of Health (“Department”).<sup>437</sup> It is the duty of the State Board of Health (“Board”) to promulgate rules implementing the EMS statute, and the duty of the Commissioner of Health (“Commissioner”) to coordinate the program at the state level. The Commissioner’s duties include preparing and maintaining a comprehensive statewide EMS plan; assisting organizations, EMS providers, ambulance authorities, and district boards through professional advice or technical assistance; and to coordinate the efforts of local government units to establish service districts, as well as evaluate proposed districts areas and operational systems “to determine the feasibility of their economic and health services delivery[.]”<sup>438</sup>

### **37. Oregon**

EMS in Oregon is governed by OR. REV. STAT. §§ 431A.050–431A.105.<sup>439</sup> The Oregon Health authority is charged to develop a comprehensive EMS system.<sup>440</sup> This includes administering and regulating ambulances, training and licensing EMS providers, and establishing EMS systems through the Emergency Medical Services Committee.<sup>441</sup>

The statute explicitly states the legislature’s intent to maintain local control of EMS, declaring that:

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<sup>436</sup> OKLA. STAT. tit. 19, § 1211.

<sup>437</sup> OKLA. STAT. tit. 63, § 1-2510.

<sup>438</sup> OKLA. STAT. tit. 63, § 1-2511.

<sup>439</sup> OR. REV. STAT. § 431A.050.

<sup>440</sup> OR. REV. STAT. § 431A.050.

<sup>441</sup> OR. REV. STAT. § 431A.085.

[T]he regulation of ambulance services and the establishment of ambulance service areas are important functions of counties, cities and rural fire protection districts in this state. It is the intent of the Legislative Assembly in ORS 478.260, 682.027, 682.031, 682.041, 682.062, 682.063 and 682.066 to affirm the authority of counties, cities and rural fire protection districts to regulate ambulance services and areas and to exempt such regulation from liability under federal antitrust laws.<sup>442</sup>

Every county must, or two or more contiguous counties may, develop a plan regarding the need for “and coordination of ambulance services and establish one or more ambulance service areas consistent with the plan for the efficient and effective provision of ambulance services.”<sup>443</sup> The county plan includes consulting with persons, cities and districts with regard to the plan and to the boundaries of any ambulance service areas established under the plan. Additionally, any organization that provides or wishes to provide ambulance services may notify the county if it wants to be consulted regarding the county ambulance services plan.<sup>444</sup> The Oregon Health Authority receives the plan and proposed service areas and approves the plans if they comply with the relevant rules.<sup>445</sup>

When a county plan is not adopted under OR. REV. STAT. § 682.062:

[A] person or governmental unit may provide ambulance services within the county, and a city or rural fire protection district may provide such services within and outside the city or district boundaries in accordance with policies adopted by the governing body of the city or district, including operation in other districts or cities by intergovernmental agreement under ORS chapter 190.<sup>446</sup>

The Health Authority rules also specify that each county is solely responsible for designating and administering the process of selecting an ambulance service provider.<sup>447</sup> In the

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<sup>442</sup> OR. REV. STAT. § 682.041.

<sup>443</sup> OR. REV. STAT. § 682.062.

<sup>444</sup> *Id.*

<sup>445</sup> *Id.*

<sup>446</sup> OR. REV. STAT. § 682.066.

<sup>447</sup> OR. ADMIN. R. 333-260-0070(1) (Lexis Advance through changes published in the Apr. 4, 2021 Oregon Bulletin).

county plan, the county must address the process for assigning and reassigning an ambulance service provider to an Ambulance Service Area (“ASA”), responding to a notification that an ASA is being vacated and maintaining the existing level of service when a provider is vacating an ASA, and the county shall designate one emergency ambulance provider for each ASA but may designate one or more non-emergency ambulance provider for each ASA.<sup>448</sup>

### **38. Pennsylvania**

EMS in Pennsylvania is governed by 35 PA. CONS. STAT. § 8101 *et seq.*<sup>449</sup> The Department of Health (“Department”), assisted by the state advisory board, will plan, guide, and coordinate programs for efficient operation of statewide and regional EMS systems.<sup>450</sup> This includes establishing statewide licensing standards, determining the number and distribution of EMS providers, administering contracts, and assisting local governments.<sup>451</sup>

Pennsylvania also has established regional councils to implement all of the objectives of the statewide plan as well as prepare a regional plan.<sup>452</sup> The councils specifically are tasked with maintaining an emergency services system within a specific geographic area, and defines the system as the “arrangement of personnel, facilities, and equipment to manage emergencies” within that geographic area.<sup>453</sup> The organizational structure of a regional council must be one of the following:

- (1) A unit of general local government, with an advisory council, meeting requirements for representation.
- (2) A representative public entity administering a compact or other areawide arrangement or consortium.

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<sup>448</sup> OR. ADMIN. R. 333-260-0070(2) (Lexis Advance through changes published in the Apr. 4, 2021 Oregon Bulletin).

<sup>449</sup> 35 PA. CONS. STAT. § 8101 *et seq.* Please note that all citations to 35 Pa. Cons. Stat. Ann. § 8101 *et seq.* herein are current through 2021 Reg. Sess. Act 9; P.S. documents are current through 2021 Reg. Sess. Act 9 (Lexis Advance).

<sup>450</sup> 35 PA. CONS. STAT. § 8105.

<sup>451</sup> *Id.*

<sup>452</sup> 35 PA. CONS. STAT. § 8109(a)–(b).

<sup>453</sup> 35 PA. CONS. STAT. § 8103.

- (3) Any other public or private nonprofit entity that meets requirements for representation as determined by the department.

Regional councils must also consult with regional medical directors.<sup>454</sup> Service areas are determined through licensure, as EMS agencies may only provide service “at a location through which it is licensed to provide that service.”<sup>455</sup> The license certificate that each EMS agency is granted will specify the locations and the name of the regional EMS service through which the license was processed.<sup>456</sup>

### **39. Rhode Island**

EMS in Rhode Island is governed by R.I. GEN. LAWS § 23-4.1 *et seq.*<sup>457</sup> The Department of Health, led by the director of health, develops a statewide plan, supervises and regulates EMS services, and grants licenses to ambulance providers.<sup>458</sup> There is also an ambulance service coordinating advisory board.<sup>459</sup> There is no reference to service areas, districts, or regions in either the statute or administrative rules.<sup>460</sup> There is also no reference to the role municipalities or counties play in the EMS system.<sup>461</sup>

### **40. South Carolina**

EMS in South Carolina is governed by S.C. CODE § 44-61-10 *et seq.*<sup>462</sup> EMS is under the control of the Department of Health and Environmental Control (“Department”) which runs a

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<sup>454</sup> 35 PA. CONS. STAT. § 8109(d).

<sup>455</sup> 28 PA. CODE § 1027.1(c) (Lexis Advance through the April 2021 supplement changes effective through 51 Pa Bulletin 676, Jan. 30, 2021).

<sup>456</sup> *Id.*

<sup>457</sup> R.I. GEN. LAWS § 23-4.1 *et seq.* Please note that all citations to R.I. GEN. LAWS § 23-4.1 *et seq.* herein are current through Ch. 4 of the 2021 Session (Lexis Advance).

<sup>458</sup> R.I. GEN. LAWS § 23-4.1-6.

<sup>459</sup> R.I. GEN. LAWS § 23-4.1-2.

<sup>460</sup> *See generally* 216 R.I. CODE R. § 020-10-2 (Lexis Advance through Mar. 22, 2021).

<sup>461</sup> *Id.*

<sup>462</sup> S.C. CODE § 44-61-10 *et seq.* Please note that all citations to S.C. CODE § 44-61-10 *et seq.* herein are current through Act No. 18 of the 2021 Reg. Sess. (Lexis Advance).



statewide program with an Emergency Medical Services Advisory Council and State Medical control Physician.<sup>463</sup> The EMS program run by the Department includes regulation and licensing of all types of ambulance services.<sup>464</sup> However, there is an explicit charge that “in developing these programs for regulating and licensing ambulance services, the programs must be formulated in such a manner so as not to restrict or restrain competition.”<sup>465</sup> An application for a provider license requires that the applicant provide a location and description of the place or places from which the provider intends to operate.<sup>466</sup> This is the only reference to any sort of service area in the statute or regulations. Counties have the authority to provide ambulance services, either directly or by contract with municipalities or private agencies.<sup>467</sup>

#### **41. South Dakota**

EMS in South Dakota is governed by S.D. CODIFIED LAWS § 34-11 *et seq.*<sup>468</sup> Ambulance districts are created and governed by the statute.<sup>469</sup> In South Dakota, any county or municipality may provide ambulance services and enter into agreements for such services.<sup>470</sup> The statute also explicitly states that any municipality or county “may license and regulate persons providing such services.”<sup>471</sup> However, the Department of Health (“Department”) is still a licensing agency for ambulance services.<sup>472</sup>

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<sup>463</sup> S.C. CODE § 44-61-30(A).

<sup>464</sup> S.C. CODE § 44-61-30(B)(1).

<sup>465</sup> *Id.*

<sup>466</sup> S.C. CODE REGS. 61-7, Section 400(A) (Lexis Advance through S.C. Reg. Vol. 45, Issue 4, eff. Apr. 23, 2021).

<sup>467</sup> S.C. CODE § 44-61-10.

<sup>468</sup> S.D. CODIFIED LAWS § 34-11 *et seq.* Please note that all citations to S.D. CODIFIED LAWS § 34-11 *et seq.* herein are current through acts received as of Mar. 31, 2021, of the 2021 Gen. Sess. of the 96th S.D. Legislative Assembly, Supreme Court Rule 20-06 and the 2020 General Elections Results (Lexis Advance).

<sup>469</sup> *Id.*

<sup>470</sup> S.D. CODIFIED LAWS § 34-11-1.

<sup>471</sup> *Id.*

<sup>472</sup> S.D. CODIFIED LAWS § 34-11-2.

There is also a process by which members of a rural territory may form and maintain an ambulance service district by petitioning the county auditor or board of county commissioners.<sup>473</sup> A municipality within the area may be included in the district if either 20% of registered voters sign a petition or if the governing body of the municipality passes a resolution indicating intent to join.<sup>474</sup> The board of county commissioners determines whether the proposed district is “suited to the ambulance service policy of the county” or each of such counties determine the boundaries of the proposed district.<sup>475</sup> Once a district is established, and the board of directors elected, the board of directors has the general powers to manage the ambulance service program, establish and maintain an ambulance service to serve the district, and to enter into contracts in the name of the district.<sup>476</sup>

## **42. Tennessee**

EMS in Tennessee is governed by TENN. CODE § 68-140-301 *et seq.*<sup>477</sup> The system is run by a statewide office of EMS, within the Department of Health and Environmental control. that is subject to the rules of the Tennessee emergency medical services board.<sup>478</sup> The regulations specifically address ambulance operations. The rules require each base of operations to hold a State-issued service license for the county in which it is located.<sup>479</sup> Additionally, no ambulance service “shall position, post, stage or otherwise offer or make an ambulance service area where the county, municipality or special purpose district or authority has current ordinances or resolutions

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<sup>473</sup> S.D. CODIFIED LAWS § 34-11A-1.

<sup>474</sup> S.D. CODIFIED LAWS § 34-11A-2.

<sup>475</sup> S.D. CODIFIED LAWS § 34-11A-7.

<sup>476</sup> S.D. CODIFIED LAWS § 34-11A-16.

<sup>477</sup> TENN. CODE § 68-140-301 *et seq.* Please note that all citations to TENN. CODE § 68-140-301 *et seq.* herein are current through the 2021 First Extraordinary Sess. and Ch. 39 (excluding Ch. 36) of the 2021 Reg. Sess. (Lexis Advance).

<sup>478</sup> TENN. CODE § 68-140-302.

<sup>479</sup> TENN. COMP. R. & REGS. 1200-12-01-.14(2)(a) (Lexis Advance through Mar. 31, 2021).

preventing such” unless there is prior authorization from the governing body of the service area.<sup>480</sup>

Additionally, the division recognizes three main classes of service for ambulance and EMS licensing. Category A is a primary emergency provider, which is:

Each ambulance service the local government designates as the primary provider by recognizing it as such or contracting with it to provide initial response to scene emergencies shall operate advanced and/or basic life support ambulances within the service area 24 hours a day. The service may also provide ambulance transport services under its license for its county specific service area. It shall coordinate licensed volunteer ambulance services as well as coordinate and oversee emergency medical response agencies within its jurisdiction.<sup>481</sup>

Category B addresses transport services and Category C addresses volunteer not-for-profit ambulance services.<sup>482</sup>

### **43. Texas**

EMS in Texas is governed by TEX. HEALTH & SAFETY CODE §§ 773.021 – 774.004.<sup>483</sup> The department of health divides the state into emergency medical services delivery areas “that coincide, to the extent possible, with other regional planning areas.”<sup>484</sup> EMS in Texas requires a state plan<sup>485</sup> as well as area plans.<sup>486</sup> In formulating area plans, the department shall:

- (1) Identify all public or private agencies and institutions that are used or may be used for emergency medical services in each delivery area; and
- (2) Enlist the cooperation of all concerned agencies and institutions in developing a well-coordinated plan for delivering emergency medical services in each delivery area.
- (3) A delivery area plan must include an interagency communications network that facilitates prompt and coordinated

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<sup>480</sup> TENN. COMP. R. & REGS. 1200-12-01-.14(2)(b) (Lexis Advance through Mar. 31, 2021).

<sup>481</sup> TENN. COMP. R. & REGS. 1200-12-01-.14 (3)(c) (Lexis Advance through Mar. 31, 2021).

<sup>482</sup> *Id.*

<sup>483</sup> TEX. HEALTH & SAFETY CODE §§ 773.021 – 774.004 Please note that all citations to TEX. HEALTH & SAFETY CODE §§ 773.021 – 774.004 herein are current through the most recent legislation which is the 2019 Reg. Sess, 86th Legislature, and the 2019 election results (Lexis Advance).

<sup>484</sup> TEX. HEALTH & SAFETY CODE § 773.022.

<sup>485</sup> TEX. HEALTH & SAFETY CODE § 773.021.

<sup>486</sup> TEX. HEALTH & SAFETY CODE § 773.023.

response to medical emergencies by the Department of Public Safety, local police departments, ambulance personnel, medical facilities, and other concerned agencies and institutions.

- (4) A delivery area plan may include the use of helicopters that may be available from the Department of Public Safety, the National Guard, or the United States Armed Forces.<sup>487</sup>

Texas' EMS statute provides specific rules regarding the ability of municipalities and counties to control EMS. In licensing, an emergency medical services provider must obtain a letter of approval from: (1) the governing body of the municipality in which the applicant is located and is applying to provide emergency medical services; or (2) if the applicant is not located in a municipality, the commissioners court of the county in which the applicant is located and is seeking to provide emergency medical services.<sup>488</sup> A municipality or county may only issue a letter of approval if it determines that:

- (1) the addition of another licensed emergency medical services provider will not interfere with or adversely affect the provision of emergency medical services by the licensed emergency medical services providers operating in the municipality or county;
- (2) the addition of another licensed emergency medical services provider will remedy an existing provider shortage that cannot be resolved through the use of the licensed emergency medical services providers operating in the municipality or county; and
- (3) the addition of another licensed emergency medical services provider will not cause an oversupply of licensed emergency medical services providers in the municipality or county.<sup>489</sup>

Municipalities are also free to establish standards for an EMS provider that are stricter than the minimum standards pursuant to the Texas EMS laws.

Ambulance provider licensing requirements in Texas further elaborate on how ambulance service areas are allocated. One requirement to acquire an EMS provider license is to include both

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<sup>487</sup> *Id.*

<sup>488</sup> TEX. HEALTH & SAFETY CODE § 773.0573(1)(a).

<sup>489</sup> TEX. HEALTH & SAFETY CODE § 773.0573(2)(b).

a map and description of service area, a list of counties and cities in which the applicant proposes to provide primary emergency service, and a list of all station locations.<sup>490</sup>

#### **44. Utah**

EMS in Utah is governed by UTAH CODE § 26-8a *et seq.*<sup>491</sup> The Department of Health (“the Department”) coordinates the EMS within the state, which includes adopting rules for the licensing of ambulance providers.<sup>492</sup> The Department operates through the State Emergency Medical Services Committee (“Committee”). The Committee issues designations to emergency medical service providers<sup>493</sup>

The Department regulates the emergency medical service market by operating a statewide system that consists of exclusive geographic service areas and established maximum rates.<sup>494</sup> Each ground ambulance provider license is for an exclusive geographic service area as described in the license, and only that licensed provider may respond to an ambulance request that originated from within the provider’s exclusive geographic service area (with some exceptions).<sup>495</sup>

Providers are selected, and contracts awarded, by political subdivisions.<sup>496, 497</sup> The department must issue a license to an applicant selected by a political subdivision, for the exclusive geographic service area approved by the department, unless issuing the license would “jeopardize the health, safety, and welfare of the citizens of the geographic service area.”<sup>498</sup>

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<sup>490</sup> 25 TEX. ADMIN. CODE § 157.11.

<sup>491</sup> UTAH CODE § 26-8a *et seq.* (LexisNexis, Lexis Advance through Apr. 27, 2021).

<sup>492</sup> UTAH CODE § 26-8a-105 (LexisNexis, Lexis Advance through Apr. 27, 2021).

<sup>493</sup> UTAH CODE § 26-8a-303 (LexisNexis, Lexis Advance through Apr. 27, 2021).

<sup>494</sup> UTAH CODE § 26-8a-401(1) (LexisNexis, Lexis Advance through Apr. 27, 2021).

<sup>495</sup> UTAH CODE § 26-8a-402(1) (LexisNexis, Lexis Advance through Apr. 27, 2021).

<sup>496</sup> UTAH CODE § 26-8a-405.1(1) (LexisNexis, Lexis Advance through Apr. 27, 2021).

<sup>497</sup> “Political subdivision” is defined by statute in UTAH CODE § 26-8a-102 to include a city or town, a county, or other special service or local district that is specifically defined by statute.

<sup>498</sup> UTAH CODE § 26-8a-405.1(2) (LexisNexis, Lexis Advance through Apr. 27, 2021).

## 45. Vermont

EMS in Vermont is governed by VT. STAT. tit. 18, § 901 *et seq.*<sup>499</sup> The Secretary of Human Services, upon recommendation of the Commissioner of the Department of Health (“Department”) may adopt rules to enforce the statute.<sup>500</sup> The Department is charged with developing a statewide EMS system, including “planning, organizing, coordinating, improving, expanding, monitoring, and evaluating” EMS services.<sup>501</sup> The Department is authorized to contract for the provision of specific services to carry out the EMS statute.<sup>502</sup>

The Department may also divide the state into emergency medical services districts, “the number, size, and boundaries of which shall be determined by the Department in the interest of affording adequate and efficient emergency medical services throughout the State.”<sup>503</sup> Each district functions to “foster and coordinate emergency medical services within the district.”<sup>504</sup> There is also a primary service area designation in Vermont. An ambulance service must receive a license in which the applicant “agrees to provide coverage according to response plans developed by the EMS district board in conjunction with municipal officials.”<sup>505</sup>

## 46. Virginia

EMS in Virginia is governed by VA. CODE § 32.1-111.1 *et seq.*<sup>506</sup> The Board of Health must develop a statewide Emergency Medical Services Plan to coordinate a comprehensive and coordinated system.<sup>507</sup> The plan also incorporates regional EMS plans.<sup>508</sup> State Board of Health

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<sup>499</sup> VT. STAT. tit. 18, § 901 (Lexis Advance through Act 2 of the 2021 Sess.).

<sup>500</sup> VT. STAT. tit. 18, § 904(b) (Lexis Advance through Act 2 of the 2021 Sess.).

<sup>501</sup> VT. STAT. tit. 18, § 906(3) (Lexis Advance through Act 2 of the 2021 Sess.).

<sup>502</sup> VT. STAT. tit. 18, § 904(a) (Lexis Advance through Act 2 of the 2021 Sess.).

<sup>503</sup> VT. STAT. tit. 24, § 2652 (Lexis Advance through Act 2 of the 2021 Sess.).

<sup>504</sup> VT. STAT. tit. 24, § 2657(a) (Lexis Advance through Act 2 of the 2021 Sess.).

<sup>505</sup> 13-140-013 VT. CODE R. § 1(4.4.2.7) (Lexis Advance through Mar. 19, 2021).

<sup>506</sup> VA. CODE § 32.1-111.1.

<sup>507</sup> VA. CODE § 32.1-111.3(A).

<sup>508</sup> *Id.*

also promulgates rules that are administered by the Commissioner of the department. Regional EMS councils must develop, maintain, and distribute a comprehensive regional EMS plan for improving and coordinating delivery of EMS in the regional service area.<sup>509</sup> The plan must be approved by the Office of EMS.<sup>510</sup>

In Virginia, the EMS system is under local control to a large degree. An EMS agency (provider) must provide service within its primary service area as designated by the local EMS response plan.<sup>511</sup> A local EMS response plan is a written document that details the primary service area and responding interval standards that have been approved by the local government and the operational medical director.<sup>512</sup> An EMS agency within its primary service area is a “designated emergency response agency.”<sup>513</sup>

The EMS statute specifies that local governments can enact ordinances that have a significant impact on EMS in the municipality. Some examples that are listed in the statute are licensing requirements, limits on agency service areas, amount of providers, and limits on emergency medical service agency operations.<sup>514</sup> Additionally, any county, city, or town may provide emergency medical services to citizens by either establishing an EMS agency as a department of government or contracting for the provision of EMS through another agency.<sup>515</sup>

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<sup>509</sup> 12 VA. ADMIN. CODE § 5-31-2670 (Lexis Advance through Apr. 1, 2021).

<sup>510</sup> *Id.*

<sup>511</sup> 12 VA. ADMIN. CODE § 5-31-380 (Lexis Advance through Apr. 1, 2021).

<sup>512</sup> 12 VA. ADMIN. CODE § 5-31-10 (Lexis Advance through Apr. 1, 2021).

<sup>513</sup> 12 VA. ADMIN. CODE § 5-31-370 (Lexis Advance through Apr. 1, 2021).

<sup>514</sup> VA. CODE § 32.1-111.4:8.

<sup>515</sup> VA. CODE § 32.1-111.4:3(A).

#### 47. Washington

EMS in Washington is governed by WASH. REV. CODE §§ 18.73.005–18.73.910.<sup>516</sup> The statewide EMS system is run by the Department of Health (“Department”).<sup>517</sup> The Department must designate at least eight emergency medical services and trauma care “planning and service regions” that must ensure all parts of the state are within an area.<sup>518</sup> Regional designations are determined on the basis of providing efficient EMS and trauma care services.<sup>519</sup> Ambulance services must be licensed by the Secretary of Health.<sup>520</sup> Service licenses issued when consistent with statewide and regional EMS plans, indicating “the general area to be served.”<sup>521</sup>

The system does not integrate municipalities or counties into the provision of EMS, nor does it allow any additional restrictions to be placed by said governing authorities. Washington’s EMS Statute declares a clear intention to supersede all “ordinances, regulations, and requirements promulgated by counties, cities and other political subdivisions of the state of Washington, insofar as they may provide for the regulation of emergency medical care, first aid, and ambulance services which do not exceed the provisions of this chapter.”<sup>522</sup>

#### 48. West Virginia

EMS in West Virginia is governed by W. VA. CODE § 16-4C *et seq.* (titled “Emergency Medical Services Act”)<sup>523</sup> and W. VA. CODE § 7-15 (titled “Emergency Ambulance Service Act of

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<sup>516</sup> WASH. REV. CODE §§ 18.73.005 – 18.73.910. Please note that all citations to WASH. REV. CODE §§ 18.73.005 – 18.73.910 herein are current through Ch. 19 of the 2021 Reg. Sess. (Lexis Advance).

<sup>517</sup> WASH. REV. CODE § 18.73.030.

<sup>518</sup> WASH. REV. CODE § 70.168.110.

<sup>519</sup> *Id.*

<sup>520</sup> WASH. REV. CODE § 18.73.130.

<sup>521</sup> *Id.*

<sup>522</sup> WASH. REV. CODE § 18.73.020.

<sup>523</sup> W. VA. CODE § 16-4C *et seq.* Please note that all citations to W. VA. CODE § 16-4C *et seq.* herein are current through enacted legislation effective Mar. 21, 2021 (Lexis Advance).



1975”).<sup>524</sup> The statutes adopt a county obligation model to EMS provision in the state, stating, “the county commission shall cause emergency ambulance service to be made available to all the residents of the county where such service is not otherwise available.”<sup>525</sup> The county commission can provide the service directly through its agents; through private enterprise; by its designees; or by contracting with individuals, groups, associations, corporations, or otherwise.<sup>526</sup>

There is an Office of Emergency Medical Services (“OEMS”) within the Bureau of Public Health (“Bureau”) under the Commissioner of Public Health (“Commissioner”).<sup>527</sup> There is also an advisory council to assist the Commissioner.<sup>528</sup> One duty of the Commissioner is to develop a statewide Emergency Medical Services Implementation Plan which includes the duty to assist with and encourage local participation by area, county, and community officials and regional EMS boards of directors.<sup>529</sup> On the whole, the state employs a “local system,” which administrative rules define as:

A coordinated arrangement of resources organized to provide emergency ambulance service within a defined geographical area. The systems are provided under the authority of either a county commission, statutory ambulance authority or other legislatively-established entity charged with the responsibility for providing the service.<sup>530</sup>

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<sup>524</sup> W. VA. CODE § 7-15 *et seq.* Please note that all citations to W. VA. CODE § 7-15 *et seq.* herein are current through enacted legislation effective Mar. 21, 2021 (Lexis Advance).

<sup>525</sup> W. VA. CODE § 7-15-4.

<sup>526</sup> *Id.*

<sup>527</sup> W. VA. CODE § 16-4C-4.

<sup>528</sup> W. VA. CODE § 16-4C-5.

<sup>529</sup> W. VA. CODE § 16-4C-6.

<sup>530</sup> W. VA. CODE R. § 64-48-2 (Lexis Advance through regulations in effect as of Mar. 2021).

## 49. Wisconsin

EMS in Wisconsin is governed by WISC. STAT. §§ 256.01–257.04.<sup>531</sup> Wisconsin’s EMS laws are administered and enforced by the Department of Health Services (“Department”),<sup>532</sup> which prepares a biennial, statewide emergency medical services plan.<sup>533</sup> There is also a statewide Emergency Medical Services Board (“Board”) which provides recommendations to the Department.<sup>534</sup>

The process by which EMS providers are licensed and granted service areas is based on a process by which applications are submitted by any would-be EMS provider to the Department for review and approval.<sup>535</sup>

Any county, city, town, village, hospital, ambulance service provider, or combination thereof may, after submission of a plan approved by the department, conduct an emergency medical services program using emergency medical services practitioners for the delivery of emergency medical care to sick, disabled, or injured individuals at the scene of an emergency and during transport to a hospital, while in the hospital emergency department until responsibility for care is assumed by the regular hospital staff, and during transfer of a patient between health care facilities . . . .<sup>536</sup>

The department shall review and, if the department determines that the plans are satisfactory, approve the plans submitted under par. (a) . . . .<sup>537</sup>

If a proposed plan is approved by the Department, the Department shall:

1. Provide administrative support and technical assistance to emergency medical services programs that use emergency medical services practitioners or ambulance service providers.

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<sup>531</sup> See WISC. STAT. §§ 256.01–257.04. Please note that all citations to WISC. STAT. §§ 256.01–257.04 herein are current through 2021 Act 7 (Westlaw Edge).

<sup>532</sup> See WISC. STAT. § 256.12.

<sup>533</sup> See WISC. STAT. § 256.08(1)(a)–(b).

<sup>534</sup> See WISC. STAT. § 256.04.

<sup>535</sup> WISC. STAT. § 256.12(2)(a)–(b).

<sup>536</sup> WISC. STAT. § 256.12(2)(a).

<sup>537</sup> WISC. STAT. § 256.12(2)(b).

2. Coordinate the activities of agencies and organizations providing training for the delivery of emergency medical services.
3. Assist the development of training for emergency medical services practitioners.
4. Assess the emergency medical resources and services of the state and encourage the allocation of resources to areas of identified need.
5. Assist hospitals in planning for appropriate and efficient handling of the critically ill and injured.<sup>538</sup>

Applications being granted at the state level, rather than at a regional or municipal level, is something the system has in common with Minnesota. However, there is no “primary” service area, exclusivity, or anticompetitive aspect to ambulance service that is apparent in the regulations.<sup>539</sup>

## 50. Wyoming

EMS in Wyoming is governed by WYO. STAT. §§ 33-36101–33-36-202.<sup>540</sup> The statute grants the Department of Health, Office of Emergency Medical Services (“the Division”) to administer the EMS statute.<sup>541</sup> There is also a State EMS Advisory Committee. The Division grants ambulance business licenses to applicants who meet the statutory requirements.<sup>542</sup> The licenses expire and must be renewed after one year.<sup>543</sup>

To be granted an Ambulance Service Business License, the application must include a description of, “The location from which the ambulance service shall operate, and the boundaries of its normal area of operation.”<sup>544</sup>

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<sup>538</sup> *Id.*

<sup>539</sup> Beyond the natural exclusivity that may occur in the process of the department allocating ambulance providers licenses to provide service to one area rather than another that may already have a provider.

<sup>540</sup> WYO. STAT. §§ 33-36101 – 33-36-202. Please note that all citations to WYO. STAT. §§ 33-36101 – 33-36-202 herein are current through Ch. 158 of the 2021 Gen. Sess. of the Wyoming Legislature (Lexis Advance).

<sup>541</sup> WYO. STAT. § 33-36-103.

<sup>542</sup> WYO. STAT. § 33-36-104.

<sup>543</sup> WYO. STAT. § 33-36-104(b).

<sup>544</sup> 048-0023-2 WYO. CODE R. § 1(3)(c)(ix) (Lexis Advance through Mar. 30, 2021).

The only reference to “service areas” in the rules and regulations is in the chapter that addresses Community EMS Agencies. The proposal to form and provide services as one of these agencies must contain a description of the area to be served as well as a Memorandum of Agreement with the local ambulance service operating in the area if the Community EMS Agency is not the ambulance service providing transport. The Memorandum of Agreement must include an acknowledgment by the local ambulance service or services that a Community EMS Agency is operating in the same “service area.”<sup>545</sup> This language implies that specific service areas are designated in the granting of an Ambulance Service Business License, and that at least some coordination must take place to have additional providers in the same service area.

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<sup>545</sup> 048-0023-14 WYO. CODE R. § 1(6)(b) (Lexis Advance through Mar. 30, 2021).

## **Conclusion**

There are several key things about Minnesota's current EMS statutes and regulations that are extraordinary when compared to those of other states. First is the state's unflinchingly rigid PSA system. Second is the state's lack of meaningful local input and control over the furnishing of EMS in communities. Third is the state's heavy centralization of decision-making and oversight for EMS within the EMSRB. While there are no two states that are exactly alike in the realm of EMS, it is unequivocal that Minnesota's EMS system is highly unusual in these respects. Of course, "unusual" does not necessarily mean "bad," but there are several serious flaws with Minnesota's current EMS system, which will be explained in greater detail in the subsequent public policy analysis.

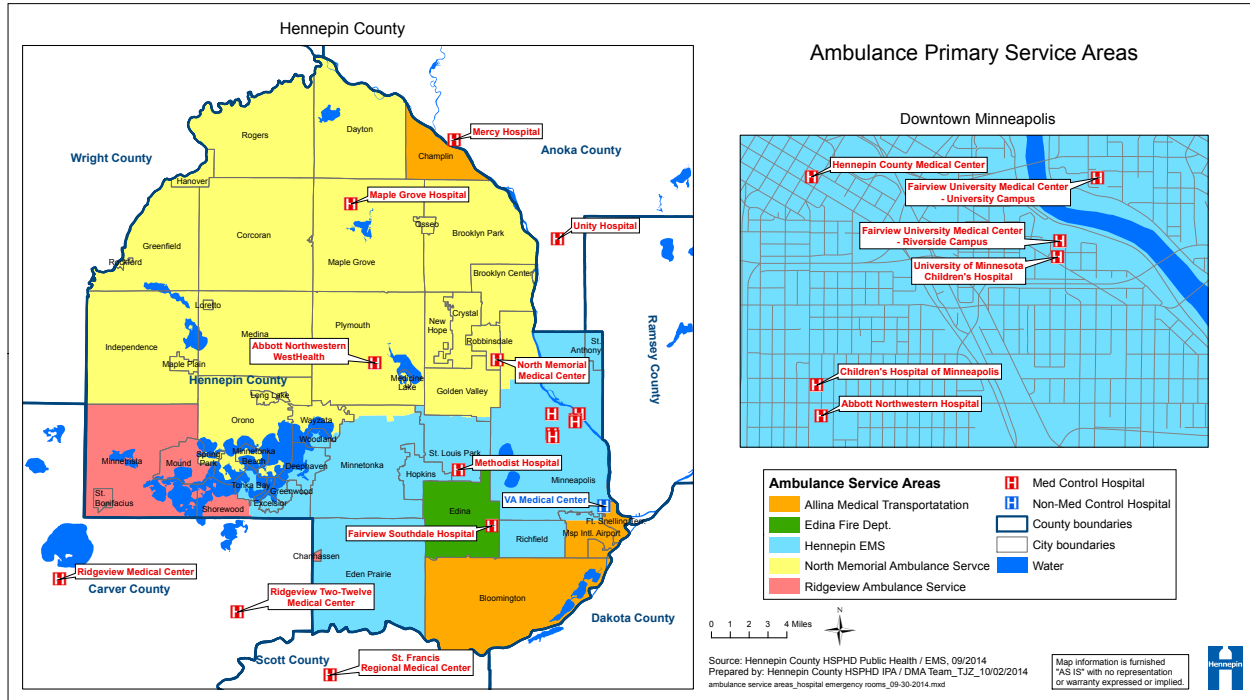
Many of the states discussed at varying lengths in the preceding section offer something that would improve Minnesota's current EMS statutes and regulations. Most notably, borrowing elements of local influence and control over EMS from other states. Even Connecticut, Minnesota's closest EMS peer, has managed to make their similarly rigid and inflexible PSA system more suitable for the realities of contemporary EMS. After all, a lot has changed since the first ambulance services began serving Minnesotans, populations have grown and shifted, cities, townships, and neighborhoods have developed, and technology has evolved exponentially. Despite all of these changes, the one constant—for over forty years—has been the state's centralized, undemocratic, and unflinchingly rigid PSA law.

## Appendices

### A. Table: State-by-State Summary of EMS Systems

State	Ambulance Licensing Authority	Notes
Alabama	Bd. of Health; Dep't of Health	Ambulance licenses issued county-by-county
Alaska	Dep't of Health & Social Services	Comprehensive statewide plan
Arizona	Dep't of Health Services	Certificate of necessity needed; not exclusive
Arkansas	Bd. of Health; Dep't of Health	Counties may establish local EMS systems
California	Emergency Med. Services Authority	State approval of local EMS plans
Colorado	Bd. of Health; County Bds. of Comm'rs	State standards, counties issue licenses
Connecticut	Dep't of Public Health	PSAs; municipalities can petition to remove
Delaware	Dep't of Health & Social Services	Primary providers in ambulance serv. dist.
Florida	Dep't of Health	Certificate of necessity needed; not exclusive
Georgia	Bd. of Pub. Health; Dep't of Pub. Health	Licenses contain no geographic restrictions
Hawaii	Dep't of Health	Comprehensive statewide plan
Idaho	Bureau of EMS & Preparedness	Self-declared geographic coverage areas
Illinois	Dep't of Public Health	Regional EMS systems; state approval
Indiana	EMS Commission	Local gov'ts may establish EMS systems
Iowa	Dep't of Health	No service area restrictions
Kansas	Emergency Med. Services Board	Local gov'ts may establish EMS systems
Kentucky	Board of Emergency Med. Services	Self-declared geographic coverage areas
Louisiana	Dep't of Health	Licenses contain no geographic restrictions
Maine	Board of Emergency Med. Services	Regional councils; Board approval
Maryland	Emergency Med. Services Board	Licenses contain no geographic restrictions
Massachusetts	Dep't of Public Health	Regional councils; service zone plans
Michigan	Dep't of Health & Human Services	Local MCAs; local gov'ts may furnish EMS
Minnesota	Emergency Med. Services Regul. Bd.	PSAs; no local control; little local input
Mississippi	Bd. of Health; Dep't of Health	Licenses contain no geographic restrictions
Missouri	Dep't. of Health & Senior Services	Ambulance service districts mostly control
Montana	Dep't. of Health & Human Services	Specific licenses
Nebraska	Dep't. of Health & Human Services	State Bd. recommends licensure, enforces
Nevada	State Bd. Health, Dist. Board Health	Depends on size of county
New Hampshire	Comm'r of Pub. Health, Board	Regional councils coordinate services
New Jersey	Off. of Emergency Med. Services	
New Mexico	EMS Licensing Commission	State-approved provider operations plan
New York	State EMS Council	Regional councils coordinate services
North Carolina	Counties	Regional systems, counties control
North Dakota	Dep't of Health	Rural ambulance serv. dist. may be created
Ohio	Bd. Emergency Med., Fire, & Transp.	Counties may compel Bd. to issue licenses
Oklahoma	Ambulance Districts	Comprehensive statewide plan
Oregon	Oregon Health Authority	County plans; local control
Pennsylvania	Dep't of Health	State & region plans; regional councils
Rhode Island	Dep't of Health	Comprehensive statewide plan
South Carolina	Dept. of Health & Envtl. Control	Local authorities; anticompetition prohibited
South Dakota	Dep't of Health; Any Muni. or County	Specific process for rural districts
Tennessee	State Office of EMS	Municipalities may restrict providers
Texas	Dep't of Health	State & region plans; local approval
Utah	State EMS Committee	Exclusive service areas w/ local control
Vermont	Dep't of Health	PSAs w/ local control & plans
Virginia	Dep't of Health	State & region plans; PSAs w/ local control
Washington	Dep't of Health	State plan; no local control
West Virginia	Counties	State plan; munis and counties control
Wisconsin	Dep't. of Health Services	Biennial plan; EMSRB makes recs
Wyoming	Off. of Emergency Med. Services	

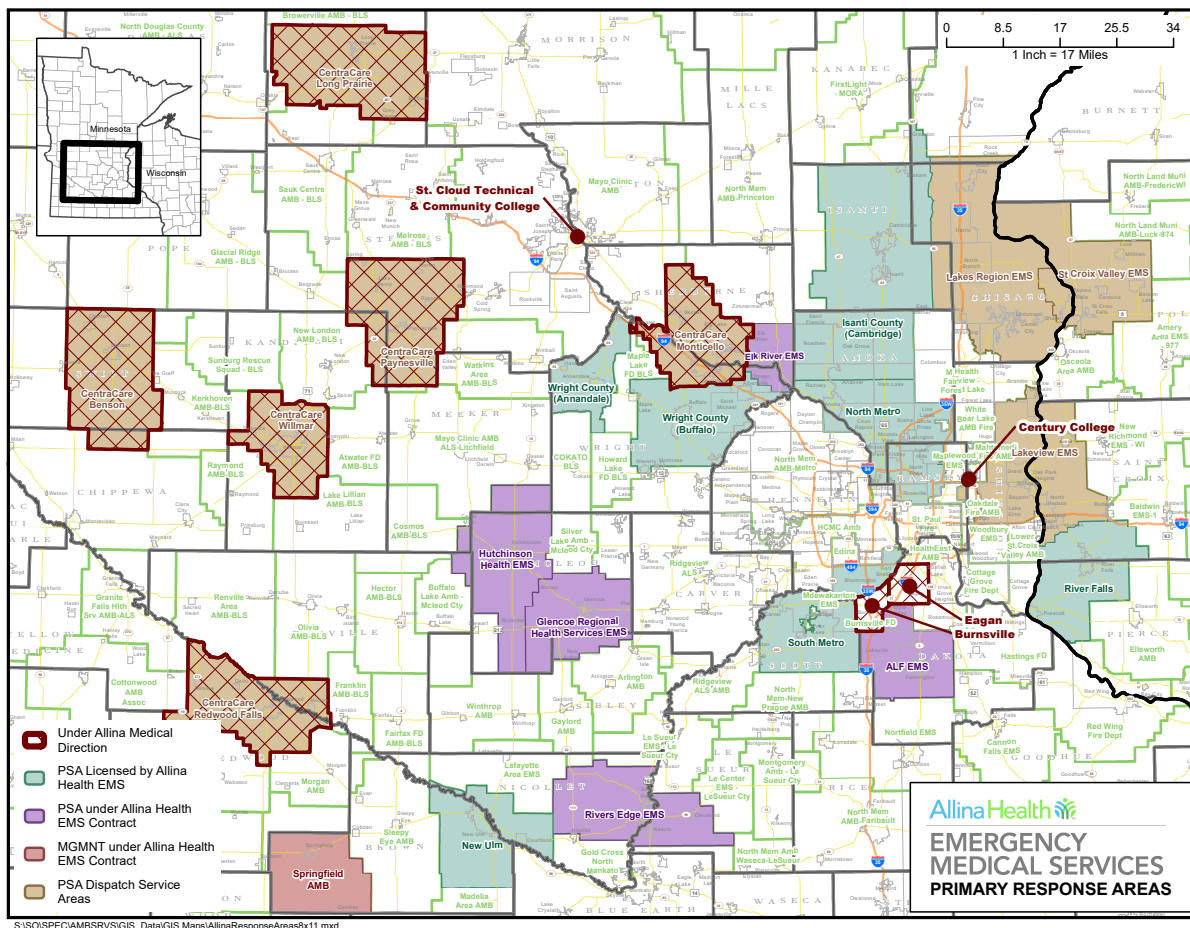
## B. Hennepin County Primary Service Areas Map



Retrieved from: <https://www.hennepinpublicdefender.org/-/media/hennepinus/business/work-with-hennepin-county/ems/ambulance-service-areas.pdf> (last visited Apr. 25, 2021).



### C. Allina Health EMS Primary Service Areas Map



Allina Health, *Emergency Medical Services Primary Response Areas*, <https://www.allinahealth.org/medical-services/-/media/allina-health/files/medical-services/allina-health-ems-primary-response-areas.pdf> (last visited Apr. 25, 2021).

## **D. Burnsville Fire Department Primary Service Area**

Minnesota Emergency Medical Services Regulatory Board (EMSRB)  
**PRIMARY SERVICE AREA**

Ambulance Service: BURNSVILLE FIRE DEPARTMENT, BURNSVILLE

EMS#: 391

Region: Metropolitan

Service Level: Advanced

The Primary Service area is within the following County or Counties: Dakota

The Primary Service includes the following Cities: Burnsville

Townships:

In Dakota Co.: (All of the corporate limits of the City of Burnsville)

T27NR24W - sections 13, 22 through 29, 32 through 36

T115NR20W - sections NW  $\frac{1}{4}$  of 16, 17 through 19, W  $\frac{1}{2}$  of 20, W  $\frac{1}{2}$   
of 29, 30, 31, W  $\frac{1}{2}$  of 32

T115NR21W - sections 13, 14, E  $\frac{1}{2}$  of 15, E  $\frac{1}{2}$  of 22, 23 through 26, E  $\frac{1}{2}$  of 27,  
E  $\frac{1}{2}$  of 34, 35, 36

This primary service area is the legal primary service area designated by the EMSRB. Any proposed changes must be reported to the EMSRB for prior approval.

## E. Arizona Ground Ambulance Service Rate Schedule (2019)

**ARIZONA GROUND AMBULANCE SERVICE RATE SCHEDULE**  
 ARIZONA DEPARTMENT OF HEALTH SERVICES, Bureau of Emergency Medical Services and Trauma System  
 150 North 18th Avenue, Suite 540, Phoenix, AZ, 85007-3248  
 Phone: (602) - 364 - 3150; Fax: (602) - 364 - 3567  
 Download this schedule at: <http://www.azdhs.gov/bems/ambulance/ground.htm>

Prepared: November 1, 2019

Prepared: November 1, 2019			RATES					EMS	Rates	Separate
CON	Type	Entity dba	ALS	BLS	Mileage	Standby	Subscription	Control	Effective	Charges For
No.	Entity					Waiting	Service	No.	Date	Disposable
										Medical
										Supplies
139	fp	ABC Ambulance	825.83	735.32	11.33	183.83		00486	04/25/19	Yes
90	fp	Action Medical Service Inc. - Ganado	1,318.94	1,318.94	16.31	329.72		00540	05/20/19	No
104	fp	Action Medical Service Inc. - Winslow	1,074.68	1,074.68	19.34	268.67		00540	05/20/19	No
101	np	Ajo Ambulance, Inc.	1,779.84	1,779.84	11.14	444.96		00841	06/21/18	No
		American Medical Response of Maricopa, LLC dba American Medical Response, dba AMR, dba SW General, Inc., dba Southwest Ambulance dba Southwest Ambulance of Casa Grande, Inc.								
136	fp	dba Southwest Ambulance and Rescue of Arizona	965.67	860.19	20.02	215.04	90.19	00430	04/08/19	Yes
134	fd	Arivaca Fire District	1,138.26	1,138.26	11.12	284.57	77.61	00762	06/21/19	No
		Arizona Ambulance of Douglas, Inc. dba Arizona Ambulance Transport	1,051.11	1,051.11	18.49	262.79		01036	08/28/18	No
120	fp	Arrowhead Fire and Medical Authority	1,576.89	1,576.89	16.73	80.87	67.05	00740	05/31/18	No
110	fp	Avra Valley Fire District	1,361.19	1,361.19	12.89	333.29		00430	04/08/19	No
5	fd									
131	fp	Baker Emergency Medical Services, Inc.	872.00	769.00	16.00	192.25		3157	03/02/09	No
124	fd	Beaver Dam/Littlefield Fire District	1,123.14	1,123.14	13.88	279.01		00437	04/09/19	No
		Bisbee, City of								
100	muni	dba Bisbee Fire Department	947.87	947.87	16.73	236.96		3866	06/03/13	Yes
		Blue Ridge Fire District								
128	fd	Blue Ridge Fire Department	2,093.00	2,093.00	11.43	523.25		00042	08/08/19	No
		Buckeye Valley Rural Volunteer Fire District								
8	fd	dba Buckeye Valley Volunteer Rescue Unit	1,206.98	1,206.98	15.38	301.76		00885	08/02/19	No
39	fd	Bullhead City Fire Department Ambulance Service	1,161.28	1,161.28	15.93	290.31		00587	05/20/19	No
		Colorado City Fire District								
22	fd	dba Colorado City Fire Department	1,240.05	1,240.05	20.06	NONE		00437	04/09/19	only Oxygen
3	fd	Copper Canyon Fire & Medical District	1,666.79	1,666.79	11.48	416.69		00912	08/12/19	No
105	fd	Daisy Mountain Fire District	1,185.85	1,185.85	13.79	NONE		00532	05/20/19	No
		Douglas, City of								
32	muni	dba Douglas Ambulance Service	1,341.40	1,341.40	11.33	335.35		00486	04/25/19	No
		Drexel Heights Fire District								
11	fd	dba Drexel Heights Fire Department	1,583.96	1,583.96	22.61	395.98		00469	04/17/19	No
		Elfrida Fire District								
17	fd	dba Elfrida Ambulance Service	945.79	945.79	16.28	217.12		00105	06/01/19	No
		Eloy Fire District								
13	fd	dba Eloy Fire District Ambulance Service	1,583.96	1,583.96	22.61	395.98		00469	04/17/19	No
		Flagstaff Medical Center								
26	hosp	dba Guardian Medical Transport	1,398.75	1,398.75	22.51	349.70		00105	06/01/19	Yes
29	fd	Forest Lakes Fire District	1,950.67	1,950.67	16.13	487.67		00105	06/01/19	Yes
82	fd	Fort Mojave Mesa Fire Department	1,123.23	1,123.23	16.04	77.44		00587	05/20/19	No
18	fd	Fry Fire District	1,146.38	1,146.38	15.93	286.61		00885	08/02/19	Yes
		Gila Bend, Town of								
78	muni	dba Gila Bend Rescue/Ambulance	2,819.08	2,819.08	11.18	704.77		00691	02/14/19	No
		Gilbert, Town of								
149	muni	dba Gilbert Fire & Rescue Department	913.01	813.65	15.80	203.42		0562	06/07/17	Yes
		Golden Shores Fire Department								
40	fd	dba Golden Shores Fire Department Ambulance Service	1,246.64	1,246.64	11.67	311.66		01136	10/07/19	No
56	fd	Golder Ranch Fire District	1,387.38	1,387.38	14.09	346.84	94.24	00469	04/17/19	Yes
150	fd	Green Valley Fire District	1,368.33	1,237.47	11.41	309.37		00885	08/02/19	Yes
		Greenlee County Ambulance Service								
84	cnty	dba Greenlee County EMS	1,300.30	1,231.38	11.11	55.62		01009	09/17/19	No
103	fp	Healthcare Innovations, Inc.	1,635.88	1,635.88	18.01	408.97		00105	06/01/19	Yes
4	fd	Heber-Overgaard Fire District	1,500.90	1,500.90	11.29	NONE		00885	08/02/19	No
88	np	Holbrook E.M.S., Inc.	1,406.72	1,406.72	19.91	351.67		00430	04/08/19	No
		Kearny, Town of								
23	muni	dba Kearny Ambulance Service, Town of	1,279.00	1,279.00	14.51	319.75		00469	04/17/19	No

\*\*\* Phoenix Rate Group    ^^^ Tucson Rate Group  
 fd = fire district            fp = for profit  
 np = non profit              cnty = county  
 muni = municipality        hosp = hospital  
 trbl = tribal

**ARIZONA GROUND AMBULANCE SERVICE RATE SCHEDULE**  
 ARIZONA DEPARTMENT OF HEALTH SERVICES, Bureau of Emergency Medical Services and Trauma System  
 150 North 18th Avenue, Suite 540, Phoenix, AZ, 85007-3248  
 Phone: (602) - 364 - 3150; Fax: (602) - 364 - 3567  
 Download this schedule at: <http://www.azdhs.gov/bems/ambulance/ground.htm>

Prepared: November 1, 2019

CON No.	Type Entity	Entity dba	RATES					EMS Control No.	Rates Effective Date	Separate Charges For Disposable Medical Supplies
			ALS	BLS	Mileage	Standby Waiting	Subscription Service			
99	fd	Lake Mohave Ranchos Fire District	1,845.11	1,845.11	15.01	461.28		00752	06/19/18	No
62	fp	Life Line Ambulance Service, Inc.	1,645.98	1,645.98	24.64	169.78	54.52	00430	04/08/19	Yes
147	fp	Maricopa Ambulance LLC***								
		dba Maricopa Ambulance	965.67	860.19	20.02	215.04		00430	04/08/19	Yes
117	fd	Mayer Fire District Ambulance Service	1,646.65	1,646.65	11.51	411.67		00105	06/01/19	Yes
		Mesa, City of								
140	muni	dba Mesa Fire and Medical Department	921.85	921.85	19.11	NONE		00105	06/01/19	Yes
38	fd	Mohave Valley Fire Department Ambulance Service	1,339.58	1,339.58	16.42	334.90		00628	05/30/18	No
		Nogales Fire Department, City of								
30	muni	dba Nogales Ambulance Service	1,249.04	1,249.04	16.28	312.25		4035	06/01/15	No
114	fd	North County Fire & Medical District	1,297.33	1,297.33	16.01	324.33		01009	09/17/19	No
138	fd	Northwest Fire District	1,158.48	1,158.48	19.81	NONE		00820	05/03/19	No
102	muni	Page Fire Department Ambulance Service, City of Peoria, City of ***	1,043.48	1,043.48	12.28	61.27		3743	06/01/12	No
146	muni	dba Peoria Fire and Medical Dept.	965.67	860.19	20.02	215.04		00430	04/08/19	Yes
76	muni	Phoenix ETS (Emergency Transportation Services), City of ***	965.67	860.19	20.02	215.04		00430	04/08/19	Yes
52	fd	Picture Rocks Fire District	1,372.36	1,372.36	18.41	343.19		0654	06/19/17	No
		Pine/Strawberry Fire District								
81	fd	dba Pine/Strawberry Fire Department	1,697.61	1,697.61	16.37	424.40		00885	08/02/19	Yes
96	fd	Pinetop Volunteer Fire District	1,624.71	1,624.71	11.90	406.18		00885	08/02/19	No
		Pinewood Fire District								
2	fd	dba Pinewood Fire Department	1,033.94	1,033.94	11.91	73.04		00105	06/01/19	No
		Professional Medical Transport, Inc. ***								
		dba PMT Ambulance, dba Life Line Ambulance								
		dba Comtrans Ambulance Service, Inc.								
		dba Comtrans Ambulance Service								
		dba Promed Transport dba American Comtrans								
71	fp	dba American Medical Response, dba AMR	965.67	860.19	20.02	215.04	90.19	00430	04/08/19	Yes
116	fd	Puerco Valley Ambulance Service	1,318.39	1,318.39	18.66	329.60		00105	06/01/19	No
		Queen Creek, Town of								
144	muni	dba Queen Creeke Fire And Medical Department	942.77	846.59	10.85	211.65		4033	02/18/16	Yes
		R/M Arizona Holdings, Inc.								
		dba Canyon State Ambulance, dba Payson Medical Transport								
58	fp	dba Lifestar EMS, dba Life Line Ambulance	1,612.19	1,612.19	24.00	124.02	114.87	00430	04/08/19	Yes
92	fd	Rincon Valley Fire District	1,547.15	1,547.15	21.94	386.79	62.94	00469	04/17/19	No
20	fd	Rio Rico Fire District	1,174.42	1,174.42	15.29	293.60		00430	04/08/19	No
143	fd	Rio Verde Fire District	1,129.61	978.61	15.35	NONE		4056	11/12/15	No
		River Medical, Inc.								
94	fp	dba Life Line Ambulance	1,557.43	1,557.43	22.55	389.38	130.36	00430	04/08/19	No
		Rural/Metro Corporation (Maricopa) ***								
		dba Rural/Metro Ambulance Service								
109	fp	dba Arizona Medical Transport, dba AMT	965.67	860.19	20.02	215.04	90.19	00430	04/08/19	Yes
55	fp	Rural/Metro Corporation (Pima) ^^^	1,237.74	1,110.75	21.17	277.70	81.23	00430	04/08/19	Yes
		Rural/Metro Corporation (Pinal)								
87	fp	dba Tri-City Med, dba Life Line Ambulance	2,296.95	2,296.95	13.19	105.39		00430	04/08/19	No
		Rural/Metro Corporation (Yuma)								
65	fp	dba Rural/Metro Ambulance Service	1,392.79	1,392.79	24.07	348.19	153.37	00430	04/08/19	Yes
127	fp	Sacred Mountain Medical Service, Inc.	971.76	971.76	12.14	242.94		00105	06/01/19	Yes
151	trbl	San Carlos Apache Tribe - Emergency Medical Services	1,875.79	1,875.79	11.43	468.95		01236	10/31/19	No
		San Luis, City of								
142	muni	dba San Luis Fire Department, City of	1,221.27	1,221.27	11.00	NONE		00532	05/20/19	No
1	fd	Sedona Fire District	1,694.51	1,694.51	13.53	423.63		00105	06/01/19	No
24	muni	Sierra Vista Fire & Medical Services	986.05	986.05	17.35	246.51		00533	05/03/18	No
		Snowflake/Taylor Ambulance Service								
47	muni	dba Taylor EMS, dba Taylor Snowflake Fire & Medical, dba TSFMD	1,445.59	1,445.59	11.33	361.39		00430	04/08/19	No
		Somerton, City of								
79	muni	dba Somerton Fire Department	1,114.70	1,114.70	19.69	282.60	127.95	00242	06/01/18	No

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**ARIZONA GROUND AMBULANCE SERVICE RATE SCHEDULE**  
 ARIZONA DEPARTMENT OF HEALTH SERVICES, Bureau of Emergency Medical Services and Trauma System  
 150 North 18th Avenue, Suite 540, Phoenix, AZ, 85007-3248  
 Phone: (602) - 364 - 3150; Fax: (602) - 364 - 3567

Download this schedule at: <http://www.azdhs.gov/bems/ambulance/ground.htm>

Prepared: November 1, 2019

CON No.	Type Entity	Entity dba	RATES					EMS Control No.	Rates Effective Date	Separate Charges For Disposable Medical Supplies
			ALS	BLS	Mileage	Standby Waiting	Subscription Service			
132	fd	Sonoita-Elgin Fire District								
		Sonoita-Elgin Ambulance	1,240.45	1,240.45	17.12	310.11		00105	06/01/19	No
12	fd	South County Fire & Medical District								
		dba Arizona Fire & Medical Authority	1,478.72	1,478.72	21.12	369.67		01009	09/17/19	No
		Southwest Ambulance of Casa Grande, Inc.								
85	fp	dba Southwest Ambulance of Casa Grand								
		dba American Medical Response, dba AMR	1,468.19	1,363.91	23.03	340.97	123.85	00430	04/08/19	Yes
		Southwest Ambulance of Tucson, Inc. ^^^								
54	fp	dba Kord's Southwest, dba American Medical Response, dba AMR	1,237.74	1,110.75	21.17	277.70	81.23	00430	04/08/19	Yes
		Southwest Ambulance Service of Southeastern Arizona, Inc.								
63	fp	dba Southwest Ambulance of Safford, dba Life Line Ambulance	1,611.42	1,611.42	13.19	105.39		00430	04/08/19	No
36	muni	St. Johns Emergency Services	1,078.72	1,078.72	15.09	86.30		00105	06/01/19	No
		Sun City Fire District ***								
145	fd	dba Sun City Fire and Medical Department	965.67	860.19	20.02	215.04	-	00430	04/08/19	Yes
		Sunsites-Pearce Fire District								
33	fd	dba Sunsites-Pearce Fire District Ambulance Service	912.99	912.99	18.26	228.24		3677	06/28/11	No
		Superior, Town of								
125	muni	dba Superior Emergency Medical Services	1,397.58	1,397.58	17.71	349.40		00242	06/01/18	No
137	fd	Superstition Fire & Medical District	1,469.56	1,362.69	16.03	NONE		00486	04/25/19	No
141	muni	Surprise Fire-Medical Department ***	965.67	860.19	20.02	215.04	-	00430	04/08/19	Yes
148	muni	Tempe Fire Medical Rescue***	965.67	860.19	20.02	215.04	-	00430	04/08/19	Yes
122	fd	Three Points Fire District	1,380.04	1,380.04	14.93	119.39		4042	04/30/15	No
		Timber Mesa Fire and Medical District								
111	fd	dba Lakeside Fire District	1,314.20	1,314.20	14.82	328.55		00885	08/02/19	No
112	fd	Tonto Basin Fire District	1,555.72	1,555.72	15.46	388.93		00430	04/08/19	No
		Tri-City Fire District								
126	fd	dba Tri-City Fire District Ambulance Service	1,854.59	1,854.59	11.18	463.65		00152	01/03/19	No
35	np	Tri-Valley Ambulance Service, Inc.	1,114.88	1,114.88	11.01	70.16	62.08	4035	06/01/15	No
		Tubac Fire District								
6	fd	dba Tubac Fire District Ambulance	1,198.80	1,198.80	13.33	299.70		00885	08/02/19	No
		Tucson, City of ^^^								
108	muni	dba Tucson Fire Department	1,237.74	NONE	21.17	NONE		00430	04/08/19	Yes
49	np	Verde Valley Ambulance Company, Inc.	1,143.70	1,143.70	19.05	272.82		00752	06/19/18	No
123	fd	Verde Valley Fire District	1,409.90	1,409.90	19.88	352.47		00242	06/01/18	No
		Whetstone Fire District								
119	fd	dba Whetstone Fire District Ambulance Service	1,116.32	1,116.32	15.27	279.06		00242	06/01/18	No
		White Mountain Ambulance Service, Inc.								
64	np	dba W.M.A.S., Inc.	1,262.00	1,262.00	16.20	66.14		00105	06/01/19	No
135	fd	Williamson Valley Fire District	1,469.95	1,469.95	10.74	NONE		3913	12/18/13	No
		Yuma, City of								
133	muni	dba Yuma Fire Department, City of	1,300.74	NONE	17.58	NONE		00221	02/22/18	No

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